HEALTH CARE DELIVERY FACILITIES IN THE NORTHEASTERN REGION

HEARING

BEFORE THE

SUBCOMMITEE ON
HOSPITALS AND HEALTH CARE

OF THE

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HOUSE OF REPRESENTATIVES

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HEALTH CARE DELIVERY FACILITIES IN THE NORTHEASTERN REGION

TUESDAY, AUGUST 9, 1983

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 208, John McCormack Post Office Building, Post Office Square, Boston, Mass., Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Kaptur, and Rowland.

Also present: Representative Moakley.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. **Edgar**. The Subcommittee on Hospitals and Health Care will come to order.

I want to welcome all of you here today and thank you for taking the time out of your schedules to participate in the third of a series of six regional hearings that we are holding across the country to look at the quantity and quality of veterans' health care.

I would like to ask unanimous consent before we begin that all the statements prepared may be part of the record.

Without objection, we will make all of those statements part of the record.

I am Congressman Bob Edgar. I chair the Subcommittee on Hospitals and Health Care. I became the chairman of the subcommittee in January of this year. For the past 2 years, I chaired the Subcommittee on Education, Training and Employment.

When I became chairman of this particular subcommittee, I determined that it was important for us to travel across the country to look at the condition of the veterans' health care facilities.

I am afraid that, if we are not careful in keeping the quality and quantity of those facilities on the cutting edge of health care, we will find great pressures in Washington to begin to dismantle pieces of that health care system.

My subcommittee members have been very diligent, and in a bipartisan way we have been able to go out and not only hold hearings, but to actually have onsite visits to old facilities, new facilities, long-term facilities, nursing home facilities, readjustment counseling centers, and specialized facilities dealing with spinal cord injury. Our hope is that we not simply go out and see six different CAT scanners or six different dialysis programs, but that we look across at all of the varied aspects of veterans' health care.

I have a statement which I would like to place in the record.[1] I am going to read parts of that statement as an opening statement; and then introduce, for opening statements, my colleagues who are present with me.

I would like to recognize them at this point.

Congressman Joe Moakley from the Boston area has taken the time to join our subcommittee. His record in Congress is outstanding as it relates to veterans' concerns. He has done a good job working with Tip O'Neill and the other members of the delegation who care about the needs of the Boston area.

We are really pleased, Joe, to have you here.

Mr. MOAKLEY. Thank you, Mr. Chairman.

Mr. EDGAR. We also have Congresswoman Marcy Kaptur with us. Marcy is a freshman Member from the beautiful State of Ohio. She is an active member of our subcommittee and has been interested particularly in looking at the facilities across the country in comparing them with the facilities in her particular area.

We also have Congressman Lane Evans, a freshman Member and Vietnam-era veteran. Lane is responsible for a piece of legislation that is now pending before the Senate to extend for 3 additional years the readjustment counseling centers for Vietnam-era veterans.

While Lane has only been in Congress for about 7 months, he has distinguished himself by being the author of that legislation.

Also, for the first time in a long time on our subcommittee, we have our own resident physician, Dr. Rowland, from Georgia, a freshman Member who comes out of the Georgia Legislature. He brings with him an expertise and background in health care and health delivery systems. He is the one we call upon to ask the tough questions in the medical area. He has done a great job for us in that area.

Let me begin by reading my statement and making sure that we at least know what the historical background is for the hearings.

Following the hearing, we will tour an independent outpatient clinic and a satellite alcohol, drug, and mental rehabilitation center.

The mayor of Boston, the Honorable Kevin White, and Governor Dukakis, as well as the entire Massachusetts congressional delegation, were invited to participate in the hearing today, and I am delighted Congressman Joe Moakley was able to be here. Congressman Ed Markey was not able to be present, but has submitted a statement for the hearing record.[2]

Mr. EDGAR. This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services to eligible veterans.

Medical district 1 served 51,662 veterans in fiscal year 1982. By 1990 it is estimated that this figure will decrease to 47,920. Outpatient visits in fiscal year 1982 totaled 976,820. By 1990, it is estimated that outpatient visits will increase to 1,225,300. The number of veterans 65 years of age or older in 1980 was 128,180, and will increase by 150 percent to 319,780 in 1990.

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[1] See p. 1.

[2] See p. 154.

Nationwide, the VA has estimated that demands placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over 65 will be veterans. Right now, due to significant unemployment, more and more veterans are coming to the VA for the first time.

I might point out it is estimated there are presently 3.3 million veterans who are age 65 or older. As you reach that age, the incidence of using veterans' facilities, particularly medical facilities, increases. In 7 years, that number will be 7.7 million veterans. And it is estimated that will triple in the next 10 years.

These facts indicate that we not only have a present problem but a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illnesses in the older veteran. We must cope with the present demand. But, more importantly, we must be prepared to accommodate the future demand on the system as well.

We must also be alert to respond to the unique and changing needs of many other segments of the veteran population. For instance, we must address the continuing serious readjustment problems faced by thousands of Vietnam era veterans.

Yet another example is meeting the medical needs of those veterans deeply concerned about the effects of exposure to the defoliant agent orange. Likewise, we must provide medical assistance to those concerned veterans who were exposed to nuclear radiation during atmospheric atomic testing.

I might point out today is the anniversary of the explosion at Nagasaki, and that particular explosion is one that causes all of us to reflect on the present nuclear question.

Additionally, the Veterans Administration medical system must remain compassionate and flexible in delivery of health care to all eligible veterans.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress. Having said this, however, I do not believe that veterans' organizations and individual veterans can sit back and do nothing. The VA's health care and other benefit programs have been enacted by the Congress as the will of a grateful nation for the sacrifices these veterans made in serving the Armed Forces of the Nation. But apart from that, the American people, as a whole, have greatly benefited from the investment in VA services and facilities.

The VA medical budget for fiscal year 1984 is approximately $8.1 billion. However, that figure represents only 2.5 percent of all national health care expenditures. At the same time, the VA has provided part of the training, through its affiliations with the private medical community, for more than one-half of all health care professionals in the United States. VA researchers have already received two Nobel Prizes in medicine.

The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension, and psychiatry, to name only a few.

This year, medical district 1 medical centers have been allocated over $7.9 million for VA-funded research. The VA is the Nation's largest health care provider, with 172 strategically located hospitals and 226 outpatient clinics serving as the primary backup to the Department of Defense medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

Another reason for these six field hearings is to learn, first-hand, of the present condition of construction, maintenance, and repair of VA medical facilities. Upon completion of the six field hearings, we will have some ideas on which to build a solid base to provide quality health care to eligible veterans in modern health care facilities. In this regard, there are several construction projects in the pipeline that will affect Massachusetts medical facilities. These are:

One, $5 million for fire and safety improvements at Boston in 1985;

Two, $18 million for design for replacement or modernization of the outpatient clinic and education addition at Boston in 1986; and

Three, $162 million for replacement or modernization of these facilities in Boston in 1987;

Four, $24 million for modernization of buildings 2 and 7 at Brockton in 1984;

Five, $11.7 million for clinical improvements and renovation of buildings 5 and 8 at Brockton in 1985;

Six, $33 million for correction of seismic deficiencies at Brockton in 1987;

Seven, $54 million for patient privacy renovations and correction of seismic deficiencies at Northhampton in 1988;

Eight, $50.5 million for an outpatient addition and other improvements at West Roxbury in 1985;

Nine, $25 million for renovation of buildings 4, 6, 7, 61, and 62 at Bedford in 1987; and

Ten, $18 million for construction of a 180-bed domiciliary at Bedford in 1988.

There are a number of other areas I could cover, going into reasons why we are holding these hearings. But I think that background information gives us enough data to begin. We have a cross-section of witnesses not only from the service organizations, but from within the VA to look at the particular needs of this area.

I would like now to call on my colleague, Joe Moakley, for any opening comments that he might have. After our opening statements from my colleagues, we will then begin promptly with the hearings.

STATEMENT OF HON. JOE MOAKLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Moakley. Chairman Edgar, I would like to thank you and the subcommittee for coming to Boston. I know that you have only chosen six sites throughout the entire country, and you did feel it was very important to come to the city of Boston to view our VA facilities.

Of course, right here in Boston proper, we have the Veterans. Administration Hospital in Jamaica Plain, which has been a fixture and a landmark for many, many years, which now handles so many veterans that I am sure we are going to need a major refurbishing or maybe even new construction on the site.

We have a great spinal injury unit in the West Roxbury VA Hospital, which I hope that you and your committee may be able to go out and see first-hand.

But I know, because of the age of the veterans, that there are more medical services going to be needed as we go into the next two decades of the century. And I think that your committee is really being very forward-looking, taking the bull by the horns at this stage, to go out and see what has to be done to insure that the veterans and their families would have the adequate medical care needed as they enter into the senior part of their lives.

So, on behalf of Governor Dukakis, Mayor White, and the entire congressional delegation, I welcome you and thank you for making Boston one of your six stops along the way.

Mr. **EDGAR**. Thank you very much.

Ms. Kaptur, any opening comments?

Ms. **KAPTUR**. I have no opening statement.

Mr. **EDGAR**. Dr. Rowland?

Dr. **ROWLAND**. Thank you, Mr. Chairman.

I just want to say I am very pleased to be in Boston. I came here first in 1976 during the Bicentennial. It is a very historical part of our country. It gives me real pleasure to be here today. I thank Congressman Moakley for coming, and for the welcome you have extended to us. I look forward to listening to the witnesses and maybe asking some questions to learn more about what we can do to improve our health care and delivery system in the Veterans' Administration.

Thank you, Mr. Chairman.

Mr. **EDGAR**. Thank you.

Joe, you might report back to the Governor, the mayor, and all the officials in the Boston area that jogging is very good around the MIT-Harvard area, particularly early in the morning. I went out and checked it out as early as I could this morning, and really appreciate the fine flat terrain you have there.

Mr. **MOAKLEY**. You can always come back anytime you want, with another subcommittee.

Mr. **EDGAR**. We would like to call as our first witness the Director of the Northeastern Region, Department of Medicine and Surgery for the Veterans' Administration, Mr. James T. Krajeck.

Would you like to come forward at this point and bring with you those Directors from each of the areas that are going to accompany you: Barbara Small, Paul McCool, and Mr. Schuerholz.

Let me welcome all of you to the hearing and indicate that we chose to begin each of our six hearings with the Director of the region that we are visiting, and to have accompanying that Director, people who run the medical facilities in that particular region, to the extent possible.

Our purpose here is to try to get an overview of the region's needs.

Jim, your full statement will be made a part of the record. You can either read your statement, or you can summarize parts of it and then we would like an opportunity to move to questions.

STATEMENT OF JAMES T. KRAJECK, DIRECTOR, NORTHEASTERN REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY BARBARA A. SMALL, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, BOSTON; WILSON J. SCHUERHOLZ, DIRECTOR, VETERANS' ADMINISTRATION OUTPATIENT CLINIC, BOSTON; AND PAUL McCOOL, REGIONAL COORDINATOR, NORTHEASTERN REGION, VETERANS' ADMINISTRATION.

Mr. **Krajeck**. Mr. Chairman and members of the subcommittee, we are pleased to appear before you today and have the opportunity to discuss the Veterans Administration Department of Medicine and Surgery's provision of health services to eligible veterans in Maine, New Hampshire, Vermont, Massachusetts, and Rhode Island.

I would like to introduce the individuals who have accompanied me this morning, starting on my right with Wilson Schuerholz, the Director of the Veterans' Administration Outpatient Clinic in Boston. Paul McCool, on my direct right, is the coordinator, medical district No. 1. And on my left is Ms. Barbara Small, Director of the Veterans' Administration Medical Center of Boston.

I would like to summarize my statement.

Department of Medicine and Surgery Health services are provided to eligible veterans in the five New England States through a medical district consortium known as medical district 1, which is composed of the Boston Outpatient Clinic and eight medical centers: Bedford, Mass. Boston, Mass.; Brockton/West Roxbury, Mass.; Manchester, N.H.; Northampton, Mass. Providence, R.I.; Togus, Maine, and White River Junction, Vt. This area comprises a total veteran population of 1,202,000.

My remarks will be confined to medical district 1.

To address the medical needs of the veteran population, the district medical centers are organized as follows: The Boston Medical Center is the tertiary hospital and provides sophisticated care and treatment to all of the district facilities, such as neurosurgery, eye surgery, CT scanning, and radiation therapy.

The West Roxbury facility performs all of the district's open heart surgery and provides specialized spinal cord injury services and care. Brockton, Bedford, and Northampton provide tertiary psychiatric treatment and care.

The medical district is authorized 4,308 hospital beds and 522 nursing home care beds. At the end of June 1983, the number of inpatients treated was 1.9 percent over a planned workload of 39,709, and the number of outpatient visits was 4.7 percent over a planned workload of 722,505. Occupancy rates were averaging 84.8 percent.

The recurring fiscal year 1983 medical care budget for medical district 1 is $305 million. In addition, the nine VA facilities have a planned research budget of $9.5 million.

The medical district maintains a very active and positive relationship with its five affiliated medical schools. The medical school affiliations are with the Boston University School of Medicine, the Tufts University School of Medicine, the Harvard Medical School, the Brown University Program in Medicine, and the Dartmouth Medical School. These affiliates provided 361 house staff officers during academic year 1982–83.

For the first 7 months of this fiscal year district facilities completed a total of 878 examinations for agent orange and 24 examinations for ionizing radiation exposure. For the same time period, services have been provided for 301 former prisoners of war.

While the present level of services is anticipated to continue for former prisoners of war, it is difficult to predict the future workload for veterans exposed to agent orange and ionizing radiation.

Services for female veterans represent about 2.7 percent of the current medical district workload. Present planning indicates that the demand for medical care services for female veterans will rise during the next 5 years. All of the medical centers, in anticipation of this increased demand, are including additional facilities in all patient care renovation projects for providing female veterans with care.

The medical district initiated planning process [MEDIPP] population estimates show a 5-percent decrease in veteran population, but a 150-percent increase in the 65 years or older veteran category. These estimates clearly indicate that district planning must address the problems of aging veterans. This means converting acute care beds to extended care or nursing home care beds, redefining missions, improving ambulatory care and outpatient facilities at some centers, and initiating or improving services to elderly veterans. To partially address this issue present plans are to convert 50 psychiatric beds to nursing home care beds at the Northampton Medical Center in fiscal year 1986 and to identify other facilities for similar conversions.

The medical centers in medical district 1 range in age from 30 to 59 years and require a great deal of maintenance and repair to keep them in good operating condition. At present, there is more than $67 million in construction projects being considered in the planning process in this district to improve patient care and support services, correct fire and safety deficiencies, improve physical plant, provide patient privacy, and maintenance and repair. Included in this amount is more than $3 million provided by the recently enacted jobs bill. The fiscal year 1984 planned allocation for maintenance and repair is $4.8 million and the minor and miscellaneous construction programs for fiscal year 1984 are funded at $15.4 million.

The medical district's construction plan for fiscal year 1984–89 includes several building modernization projects at Brockton and new clinical additions at West Roxbury, Boston, Providence, and Togus. If the agency were to approve all of the construction projects being considered in the planning process, the total fiscal year 1984–89 cost in this district would be in excess of $515 million.

I am happy to report that our ability to recruit some health care professionals has improved. Flexible scheduling for nurses, including the use of the 10-hour day and use of special salary rates as authorized by Public Law 96–330 have been very beneficial.

There is still a problem in recruiting licensed practical nurses, physical therapists, certified respiratory therapists and some specialty nurses for spinal cord injury and intensive care units. In some instances, it is difficult to recruit for these positions when the private sector is offering free medical and dental insurance and tuition-paid educational incentives.

There has been considerable progress in making the district more effective and efficient in managing its resources, particularly in the areas of ADP and laundry services. With the decentralization of ADP, facilities are preparing sites for the installation of computers in fiscal year 1984, which will streamline the medical administration and pharmacy functions and permit the formation of a data base to make management information more effective in allocating resources.

Wherever appropriate, facilities have sharing agreements with the community and other Federal agencies. The new law, Public Law 97–174, allows the VA to explore sharing possibilities and establish sharing agreements with elements of the Department of Defense. Medical district 1 will actively pursue opportunities to enhance our sharing capabilities for providing essential tests and services for all eligible veterans and military personnel.

This concludes my statement, Mr. Chairman. I and my colleagues will be glad to respond to any question you or members of the subcommittee may have.

[The prepared statement of Mr. Krajeck appears on p. 61.]

Mr. EDGAR. Thank you very much for that comprehensive statement.

Before we move to questions, I wonder if any of those who are accompanying you, who have specialized responsibility, and in several cases very positive reputations nationally for their leadership as directors of specific facilities, might have a comment.

I wonder, Barbara Small, whether or not you want to say anything about your facility or any of your concerns that you would like to raise with our subcommittee before we ask you specific questions.

Ms. SMALL. Thank you. Yes, I would like to tell you a little bit about the Boston VA in Jamaica Plain.

As Mr. Krajeck referenced, it is the major tertiary referral center for the whole district. We are particularly pleased and proud of the superb quality of care provided by our professional staff there, and is translated in more recent years into the agencywide emphasis on the aging veteran.

I thought you might be interested in our programs that pertain to the aging veteran.

We were funded this year for a neurovascular unit, which is a stroke unit, which will deal with some of the particular problems of the aging. We have a geriatric assessment unit at the hospital. We have just been funded for a comprehensive rehab center. And we have a very comprehensive home-based care program.

So that in those areas of concentration of interest for the aging veteran, we feel that we have kind of been the leader and had a great deal of support from the Veterans' Administration in that regard.

A couple of other areas that I think we are particularly proud of in the Boston area, with the hospital in Jamaica Plain is the affiliations that we have, our reputation in the medical community, the private sector, I think is extraordinary.

Our relationships with the two medical schools, both Boston University and Tufts, have been excellent in terms of support, mutual support, to the veteran programs.

Along with that, again I refer to our position in the VA district as the tertiary referral center for the district.

Third, just let me emphasize our expertise in the areas of education and training. In the areas of education alone, last year we had nearly 1,400 trainees coming through our hospital—169 house staff—which translated to about 400 house staff in terms of bodies; so that we contribute a great deal in terms of education to the community.

In research, our research for a number of years in the aging areas of aphasia, has been such that they have brought renown, worldwide renown, to the VA.

Those are the major things I think that speak to the excellence of the Boston VA Medical Center.

There are things about the facility that are not excellent. If you were to see it, you would quickly recognize that it is a 30-year-old facility. One of our physicians describes it as a 30-year-old patient with birth defects that we are just now getting around to correct.

But the place is old. We have major functional deficiencies in terms of fire and safety and energy. You would appreciate that in this hot season, some of the hospital is not air-conditioned.

We have major space deficiencies. We have about a third space deficiencies.

Mr. **Edgar**. On the air-conditioning question, was it the policy of the VA for a time, or OMB for a time, to not air-condition certain facilities?

Ms. **Small**. Apparently. As you would be aware, the hospital was designed in the 1940's and constructed in the early 1950's. I think it was the policy nationwide, not only with the VA, but with the private sector, that era of construction did not lend itself to air-conditioning of facilities.

Currently, one might ask the question: Can't you put in window air-conditioners? Our electrical system is so poor in that facility, and it is in the process of being corrected. But we could not even put in window air-conditioners because of the electrical support system.

Mr. **Edgar**. Yesterday was not a very pleasant day in your hospital.

Ms. **Small**. It really was not for anyone. I won't translate that into all the problems you can imagine in terms of morale for both staff, patients, and visitors.

A third major area of concern is in the area of staffing——

Mr. **Edgar**. You do have heat, though, in the winter?

Ms. **Small**. Most of the time.

The building is an aging building. It is deceptive when one looks at it in terms of recognizing the problems that exist and then translating that into the excellence of care that exists in that facility.

Hopefully, that will be addressed in the near future. The agency has done a major study there, and the Office of Construction and the Department of Medicine and Surgery have recommended to the Administrator a major construction program for the Boston facility that has equated now to consideration of a replacement facility.

Mr. **Edgar**. I wonder if you would translate for those of us on the committee who do not have medical backgrounds the definition of "tertiary" as it relates to your facility.

Ms. **Small**. Yes. Very simply, tertiary relates to state of the art, state of the art medicine. It is the most sophisticated up-to-date technology that exists. That is the easiest way I can translate tertiary for you. It, obviously, refers not only to the equipment that exists in the hospital, but it refers to the staff and the availability of comprehensive care for any veteran coming to the facility.

Dr. **Rowland**. Will the gentleman yield.

Maybe you could make it a little more lucid if you mention primary and secondary and make a comparison between primary, secondary and tertiary.

Ms. **Small**. Good. Primary care is, obviously, an entry level of care whereby patients would come into a primary care physician, let's say, and be screened and have a diagnosis made, and step up to a secondary level of care where there is more sophistication, perhaps an inpatient facility, and then would translate to the tertiary referral center at our hospital. So from primary to secondary and tertiary, it is a matter of entry level, diagnostic procedures, to translate then into the care.

Mr. **Edgar**. Mr. Schuerholz, would you like to go through just a similar kind of description of your facilities? I think the question, although I didn't ask it specifically, was answered. What are the three or four things you are most proud of, and what are the three or four things that are warts on your facility that you would like to describe for our committee specifically.

Mr. **Schuerholz**. First of all, I would like to thank you very much for inviting me here. It is an honor and privilege for me to give a statement.

We are particularly proud about our clinic. It is an independent out patient clinic. I believe we have five in the total VA.

You asked me about being proud. I am proud of this clinic because we are in my consideration, a lot of other peoples' consideration, No. 1—we are in region 1, we are in district 1, and I think we are in position No. 1. Not that we are competitive with other independent outpatient clinics, but we do have the greatest workload.

I think the quality of care we give is excellent. I know I am particularly proud to be the head of such a staff of physicians.

Mr. **Edgar**. How many are on your staff?

Mr. **Schuerholz**. We have 378 employees and there is somewhere around 49 on our research staff. Incidentally, our budget is somewhere around $22 million; $1.5 million of that in the research program.

No. 1, our workload is 189,000 visits in the past several years. We are keeping up with it this year. We don't seem to decrease. If we project it through, we will hit our workload, probably go a little over it.

I know we have a wonderful affiliation with Boston University Medical School, Harvard Medical School, Harvard Dental School, and Tufts.

We are unique in the fact that we do have affiliation with these schools, being an independent clinic. We are unique in the fact we have multiresearch programs at our hospital—at our clinic. We are unique in the fact that we do have a GRECC program at our clinic. I believe the group will be touring the clinic this afternoon, and I will go into a little more detail in what it is.

Let me say this: I am proud to be in an organization—I have been here for 2 years and I feel that we have no menial people in our organization. We do have problems at times with the frontline organization. I know from previous readings, it is very difficult, when we have somewhere around 800 people coming through our doors every day, sometimes a thousand. And the frontline people are perhaps our lowest paid people that are on the frontline, the receptionists, et cetera. We have very few complaints as far as taking care of veterans and it is very difficult in the education process, attitudinal training, and what have you, training how to deal with these people who have these emotional problems, et cetera.

So occasionally we do have problems with them. But there are not that many. We try to move them, when they get to the stress and burnout point.

But let me finish about my proudness. I am proud to be associated with the veterans organization of this State. My chief of staff, Dr. Record, who I may say is probably one of our chief attractions—we have no problems in our clinic recruiting or maintaining employees. We have something like 33 part-time, 33 full-time physicians on our staff, and I think we have applications, about 25 or 30 lined up now for any vacancies that might occur. And this is in all the specialties. We have all the specialties.

Let me say again, Dr. Record and I both, and Dr. Record has been a mainstay as far as attracting nothing but the best to our place. We meet monthly with the veterans organizations of this State, right over here at the JFK Building. Our interest and association with the veterans organizations are to help. I know they support our program. Any problems that exist, they come up, and we resolve them.

Their biggest problem—let me also say the volunteers that have been able to start at the clinic, a growing program, this is another thing I am proud of. We have the support of the volunteers not only from the service organizations but others.

What we need at the clinic, and we need it real bad, is a clinic that is suitable to develop quality care. What we have over there—this is our No. 1 problem—yes, we rent that building, I think it runs $800,000 a year, close to a million dollars. We have to pay for extra protective service which they contract out. We have contract protection service, and we also have contract housekeeping service.

Needless to say, we probably get probably the cheapest or less expensive, and the quality of the work is substandard.

It is hard to control an organization like that. It is hard on the maintenance and repair part, the engineering part, particularly difficult to keep the place in fire and safety hazards and so forth. So this is where we are right now.

Two years ago, when I came to the Boston Outpatient Clinic, we had a survey from the Joint Accreditation Committee. They came in. Of course we were nowhere near it.

In 2 years now we have been fighting with GSA to give us some improvements. One of the big things they did for us, what happens, for some reason or other since that time on they are planning on relocating us because the rental costs, the appraisal, what it costs to own property in that area, I think it has gone up to $32 a square foot, where we are paying $8, which would make the rent prohibitive, I guess.

At any rate, when I got there, the maintenance program was out the window. They used to have a 5-year program, where we were going to have the elevators changed and renovate this, that and the other. That changed. They didn't want to put any excessive amounts of money into that building when they knew they were going to get rid of it. So what happened over those 2 years, we did manage to get them to put a sprinkler system in for us, which has just been completed and finally accepted today.

I also might want to mention the progress has been great through those 2 years in getting some indication of what is going to happen to us, where we are going to go. It is a handicap renting a building like that when you don't have control over these factors. So I am talking about the physical plant. We have to have it modernized or relocated, suitable space for a health care facility. The space allocation in there is not—it is an office-type building, it is an old bank built in 1900 as I understand it.

Additions were put on it in 1925. The VA went in there sometime around after World War II, in there with the regional office, and then the regional office went, and we have been there since.

Mr. **Edgar**. I might point out if you spent $1 million a year for 20 years, you could build a fairly nice outpatient clinic for $20 million.

Mr. **Schuerholz**. Yes; GSA changed regional directors since I have been here.

As far as I know, that new building, the new Federal building, I got word from some of the GSA heads here, it was in the paper they are going to sell the clinic, our clinic, the VA clinic at Court Street, OK? And then we are talking about what was going to happen to us. There is a strong possibility with the new Federal building going up, which will be 4 or 5 years, I don't know the time schedule on that, the domino effect, the people they take out of the JFK Building, they will be able to put us into the low rise which will be ideal.

We need 120,000 square feet. We need parking for 50 or 60. We don't have parking for the veterans. The best thing I can say about that place is its location, where we are now. We have everything coming in there. We don't have any parking. But the location, I don't think you can beat it.

Any questions?

Mr. **Edgar**. We will get to some specific questions.

Mr. McCool—you don't have a specific facility to be concerned about, but do you have an opening comment you would like to make at this point?

Mr. **McCool**. Thank you, Mr. Chairman.

It is indeed a pleasure for me to have the opportunity to very briefly comment.

My major responsibilities as district coordinator are to coordinate this district's recommendations to the Veterans' Administration Central Office for the distribution of resources, as well as the implementation of the chief medical directors into a planning program known as MEDIPP.

In medical district 1, we are particularly proud of our planning process. The planning process we had prior to MEDIPP has eased our ability to implement MEDIPP. What MEDIPP has done for us, it has given us the capability as well as the equipment to access a sophisticated data base from the National Institutes of Health's computer. With that data base, we support or dispute the recommendations that eminate from our district planning committees, the planning committees of clinical service chiefs, as well as a district planning board which is made up of a representative from each of the 10 facilities.

Within MEDIPP, we are particularly proud of one committee, a Technology Assessment Committee, for which we have been recognized by the chief medical director. The Technology Asessment Committee is made up of clinicians in each of the major disciplines of cardiology, nuclear medicine, radiology, et cetera.

The responsibilities of that Technology Assessment Committee are to advise the medical district director as to what our technologies are in the future. We all recognize that we cannot have in each of the 10 facilities the sophisticated equipment such as nuclear magnetic resonance or CAT scans and the like. With the help of this committee, we are able to best identify what we need and where this equipment should be placed.

Thank you.

Mr. **Edgar**. Thank you very much.

I would now like to yield to my colleagues. I do have additional questions which I will ask in a moment or two, but let me ask my colleagues.

First, Marcy Kaptur.

Ms. **Kaptur**. Thank you, Mr. Chairman.

It is a real pleasure for me to be here today in the Boston area. I want you to know I came specifically, Mr. Schuerholz, because of the independent outpatient clinic. Not that I want to slight anyone else, but I come from an area, northern Ohio, which basically is connected to Ann Arbor, Mich., and structurally reports to Ann Arbor.

In my community, we have at this point a satellite clinic in a rented facility which handles probably 32,000 outpatient visits a year, but that only would account for about 19,000 patients, because they come back at least twice.

I wanted to learn a little bit more about how it is that you got to be one of the few independent outpatient clinics in the country. Do you know much about the history of your own facility? Why is it that in the Boston area, with so many other related facilities, one would have an independent outpatient clinic? I am just trying to learn what the reasoning was years ago at VA when this happened.

Anyone on the panel please feel free to comment.

Mr. **Krajeck**. I may have some fragmented information. I think that the Boston Outpatient Clinic was attached at one time, sometime in the early forties, to West Roxbury, along with the Lowell Clinic and the Worcester Clinic. For some reason or other it was separated from the West Roxbury facility and established as an independent outpatient clinic.

That is the historical basis.

Whether it is appropriate for clinics to be freestanding or satellites of a medical center I think has to be determined, predicated on geography and also on the cost effectiveness and working relationships that can be established.

Mr. **Edgar**. Would the gentlewoman yield?

Ms. **Kaptur**. Yes.

Mr. **Edgar**. I wonder if you could give us just your opinion in terms of the working relationships of how they work, in terms of independents versus satellite clinics.

Mr. **Krajeck**. In this particular district, I think it works very well as an independent outpatient clinic.

Mr. **Edgar**. Would you like all of your clinics to be independent, or do you think you should have a variety?

Mr. **Krajeck**. I think each one should be judged on its own individual merits.

Ms. **Kaptur**. Are the services that you provide at the independent clinic more general than the specialized services you provide at the satellite clinics? I am trying to understand a little bit better what the differences are between the two.

Mr. **Schuerholz**. I would say yes. The independent clinic probably does—the ones that I know—in fact, you have one pretty close to you in Columbus, Ohio.

Ms. **Kaptur**. That is right. I want to visit that one, too.

Mr. **Schuerholz**. I know, because the director has been contracting me for some advice on some of the programs they would like to get there and wanted to know my experience with them.

Just briefly looking through the history here, perhaps I can just go a little bit off here and give you some idea of what happened here in this area. In September 1954, the Boston VA Outpatient Clinic with its subclinics in Worcester and Lowell became independent under a Department of Medicine and Surgery. The justifications for its establishment, still valid, were the increase in veteran population—that is one of the big things, the aging veteran creating a growing demand for outpatient medical services. And a greater awareness of the value of health concern in general.

Those were the main reasons why these things came about—concentrated in a metropolitan area where you have the increase in population of veterans. As I understand it from a recent survey we did, most of our patients that come into our clinic live within a 10-mile radius of the clinic.

Ms. **Kaptur**. This is one of our problems in our area, because we have to send people 2½ hours to Cleveland or an hour up to Michigan and there are some serious transportation problems involved there. Also, when you are talking about some of these older veterans, it becomes quite a burden on the families and we end up paying as a Government for their transportation.

I was told many months ago that one of the reasons this might have happened structurally is that years ago when independent clinics were established, they had to be affiliated with medical colleges. Do you think that is a true statement? You talked about your relationship to Tufts and to Harvard locally.

Mr. **Schuerholz**. I am not quite sure. The five independent clinics that I know of, that we compare notes with, et cetera, I am not quite sure. L.A. comes under us, Los Angeles. They are almost up to us in workload, et cetera. I don't know whether they have an affiliation. I don't know about Columbus, either. I know they are trying to get a GRECC program out there, because they want a program like our program.

Ms. **Kaptur**. A what?

Mr. **Schuerholz**. A GRECC. The one at Lubbock, I am not sure. I really don't know. And Las Vegas, that is the other one.

Ms. **Kaptur**. Mr. Chairman, I don't want to take up any more time. I wanted to ask Ms. Small, as you look at the VA services in this area, and you look at an independent outpatient clinic, how do you find or distinguish its services versus some of the others that would be available at your satellite facilities or at your primary care or tertiary care facilities?

Ms. **Small**. Actually we have all those facilities. The hospital in Jamaica Plain has a satellite outpatient clinic in Lowell that directly relates to us. I am administratively responsible for that satellite outpatient clinic, where we have about 25,000 outpatient visits a year, and an excellent staff. And one of the pluses of that kind of relationship is the integration of the staff. Our house staff, our residency programs, are integrated with Lowell Clinic so that our house staff rotates through the Lowell Clinic as they do through the other programs.

In relationship to the independent outpatient clinic we have a excellent referral pattern whereby patients going to the outpatient clinic who require hospitalization, require sophisticated diagnostic testing, work up, are referred to us. They may come into our hospital for an inpatient episode of care and be referred back to the outpatient clinic for followup, outpatient care.

We have a dual affiliation also. We have both Boston University and Tufts, the Jamaica Plain Hospital, and there is a Boston University and Tufts relationship at the outpatient clinic. So in this particular district we have both the satellite clinics and the independent outpatient clinics with relationship to the hospitals.

Ms. **Kaptur**. Are the doctors at the outpatient clinic assigned to that facility so they cannot be transferred from the tertiary facility to that facility? They are actually your doctors? They work right in that building?

Mr. **Schuerholz**. That is right, but not to say we don't have a relationship with them, back and forth with the Boston Medical Center.

Ms. Kaptur. Thank you very much.

Thank you, Mr. Chairman.

Mr. Edgar. Congressman Evans.

Mr. Evans. I noticed in your statement that your actual workload for both the hospital inpatient care and outpatient care was way over what your planned workload was. We know some of the factors nationwide are the decline in availability of health insurance for unemployed people, the increasing numbers of retired veterans and veterans over age 65 going to our health care facilities are part of that reason. Are those specific reasons why your workload is greater, or are there other reasons as well?

Mr. Krajeck. We know that the number of applications are up in the area. And we also know that the number of people who are 55 or older, the number of hospitalizations have increased for the elderly veteran.

Mr. Evans. Are there other reasons besides the unemployment and the aging that you might be able to pinpoint?

Ms. Small. If I may interject a response at this time, I think the VA in this area is recognized as a credible health care delivery system.

We are finding that with the economics in this area, and you have already addressed that issue, but with some of the crunch that the private sector hospitals are feeling in terms of reimbursement for the future, they are beginning to control their workload in ways that they never had in the past. So that we are seeing some veterans who are coming to the VA for the first time. They are now entering the system. I suspect, and we can only project, that that will increase in numbers.

The one thing, if I may interject at this point, is a comment about the widespread belief that we are having a trickle-down effect from the Northeast down South of the veteran population. I think obviously that is accurate. We know what is happening down south. I spent 3 years in Tampa before coming to Boston.

However, I think it is a false premise to assume that all of those people who are going to Florida were users of the VA system here in Boston or in the Northeast. I think they were obviously eligible users, potential users, but did not use the system. So for one to adopt the premise that we are losing our workload to the South, I think is a false premise.

Our workload continues to consist of an extraordinarily poor, very ill, aging population who have chronic diseases also but have extraordinarily difficult acute episodes of care which we are going to continue to provide for.

Mr. Edgar. If the gentleman would yield, I think that is an important point for us to remember as we head off to Florida next month to look at their influx of population, as well as planning for the future.

I think that a number of our colleagues who are from the South often indicate to us that they have a greater need than we do in the Northeast and Midwest. I think the age of our facilities, the poverty level of the patient load, I think all indicate specialized needs in this area as well as the point that you make, that population that uses the facility hasn't the mobility to leave this area and go to another area in the South.

Does the gentleman have any additional questions?

Mr. **Evans**. Yes. I would like to ask a question about agent orange.

What procedures do you have for conducting those agent orange examinations and do you have environmental physicians on staff to conduct those?

Ms. **Small**. Yes, we do. No. 1, we have very, very elaborate procedures for not only inviting veterans to come into the hospital to present with an agent orange questionable situation, but we do have the environmental physicians. We have a sophisticated follow-up program.

Just a little statistic for you. We found from 1981 to the present time that there are more agent orange examinations being performed, more veterans are presenting to have the screening that goes along with the agent orange treatment process in contradiction to the number of Vietnam veterans who are presenting for admission to the hospital. So that the program is elaborate.

The VA has been very, very specific about those things that we will do. We do a lot of publicity in terms of going out to the campuses and going out into the streets, so to speak, inviting people, educating people to the fact that we are available to do that type of screening and they need to come in.

Mr. **Schuerholz**. Do you want the clinic's remarks?

We have the same programs. We have three environmental physicians at the clinic. We found out and the record shows that in 1978 we had 9 examinations; 1979, we had 74. In 1980 was our greatest year; we had 231; in 1981, 136; in 1982, 84; in 1983, we have 52 already. We project 75 for the year. So it is dropping down since 1980.

Fourteen exams are presently pending completion. The number of exams have decreased since the high in 1980. We don't know why it has decreased but the greatest number of veterans have already had their exams. That is about all we can say as far as that is concerned.

Mr. **Evans**. One final question. I notice you are able to project the planned increase in older veterans but you just generalized in regards to level of increase in female veterans.

Can you project the numbers of female veterans that will be coming through the VA health care system in the next few years, or have you been able to plan the same way as for older veterans?

Mr. **Schuerholz**. We have 260 as far as the clinic situation—260 female patients on our rolls. That is 1 percent of our total load.

We have no problems as far as the skilled physicians, the privacy part. I don't think we have had any complaints yet.

Mr. **Evans**. I think you are going to see greater numbers now that we have greater numbers of women in the Armed Forces, maybe 10 years from now, and probably greater numbers of women coming into the Armed Forces in the future.

How are you able, if you are able, to project the numbers of people for planning purposes in terms of modernizing your facilities, planning new facilities—how can you prepare for that number? Are you able to project?

Ms. **Small**. We can do a number of things which we are doing for the current population of female veterans that come to us.

We have maybe one female applicant a day. That is an average for us at the Jamaica Plain Hospital. We can concentrate now to provide for the future. We can concentrate now on the patient privacy aspects, the development of procedures that one needs to have in a hospital to take care of female veterans.

I think one of the areas that we are certainly planning and trying to develop locally is in the area of anticipating what women will want in terms of preventative medicine. We know that women seem to be more prone to be interested in areas of preventative medicine. We are trying to explore that.

The agency has just recently appointed a rather sophisticated advisory committee group of people to advise us on the veteran female population. If the rise in those going into the active duty military continues, we obviously know we are going to have increased numbers.

Mr. **Evans**. Thank you.

Thank you, Mr. Chairman.

Mr. **Edgar**. I might point out at this point to clarify the record on the issue of the women's advisory board with the VA. We are very pleased that Mr. Walters has gone ahead and established such a board.

We are also moving legislatively to accomplish the same thing. I think it was the impetus of that legislation that nudged the idea along to have a women's advisory board, not only at the central office, but to try to get all of the regions looking at accessibility of female veterans within the system and to look at some of the problems of women veterans.

Congressman Moakley.

Mr. **Moakley**. Thank you very much.

I think you can see the sincerity of the chairman when he talks about going down to Florida in August or September. Most chairmen would wait until January or February to go down and look at Florida—especially since September is the heart of the hurricane season.

Ms. Small, I was interested in your statement about some of the things that are not completely OK in Jamaica Plain—the age of the building, the lack of adequate air-conditioning. I know that you do have some kind of request pending now for restructuring, refurbishing your organization.

Would you tell the committee a little bit about what is in the plans?

Ms. **Small**. Yes, sir. Thank you.

Very briefly, problems began to be identified in that facility in the early 1970's relative to the space and functional privacy, safety, fire and safety issues. And the hospital submitted to central office a project to be considered for an addition to the hospital and correction of some of these space deficiencies. That project grew over the years until 1981.

The Office of Construction funded an advanced planning funding project for an architect engineer to look at the hospital totally—seismically, spacewise, all its deficiencies—and come up with a plan and the number of dollars it would take to renovate the hospital, make it whole, and correct all the deficiencies. That plan was presented by the Office of Construction to the Department of Medicine and Surgery in July of this year and it went thusly.

That in order to make the hospital whole, create new space and correct deficiencies, the VA would have to engage in a four-phase construction program, probably existing over the next 10 to 12 years, for a total outlay of approximately $256 million.

During that 10- to 12-year construction time, there would be portions of the hospital that would have to be shut down, patient care areas, and the heart of the hospital, which is the existing building and the patient care areas now, would be the last phase to be renovated. Even with that renovation, one would be restricted to doing anything relative to new ward sizing, et cetera, because of the constraints of the present building.

So the Office of Construction in its wisdom made the recommendation to the Department of Medicine and Surgery that the most appropriate thing to do would be to look at replacement facilities.

The $256 million over the next 10 to 12 years is an astronomical figure to end up with something that is less than adequate. And, No. 2, that a replacement facility would probably equate to less expenditure of dollars. So that the posture that the Department of Medicine and Surgery has now taken was presented to Mr. Walters for consideration. We have not had a decision yet.

Mr. MOAKLEY. Mr. Chairman, I was wondering if any of these figures—I am sure none of these figures you have in your opening statement have anything to do with the proposed replacement or refurbishing of this facility?

Mr. EDGAR. It does not have anything to do with the replacement of the facilities, as I understand it.

Mr. MOAKLEY. All right.

Then, Ms. Small, what you are saying is that rather than refurbish or modernize, probably the $256 million would be adequate to replace the existing structure?

Ms. SMALL. Yes. The Office of Construction has estimated, and there is a formula for doing it, to replace the current number of beds that we have today with new facility, would be in the neighborhood of $200 million plus, depending upon whether one had to buy space or not.

Mr. MOAKLEY. Then you wouldn't have to interfere with the ongoing medical services being carried out at the present hospital.

Ms. SMALL. That is right. The most attractive feature of that obviously is if we go the modernization, renovation route, we are talking about 10 to 12 years of construction and disruption. If a new facility were to be considered, a replacement facility, that could be built in 3½ years' time. So we are talking about not only the economies of money, but the economies of service and time.

Mr. MOAKLEY. Are there any other hospitals in the general area anywhere as old as the Jamaica Plain Hospital?

Ms. SMALL. I heard the regional director say that the ages in the area were from 30 to 59. I know the Jamaica Plain is 30. I don't know the 59-year-old facility.

Mr. KRAJECK. In fact, our oldest facility is at North Hampton and Togus.

Mr. MOAKLEY. What size are those facilities?

Mr. **Krajeck**. Well, they have different functions. I think the thing that we will want to impress on you is that just because a facility has a certain age doesn't necessarily mean that it is functional or not functional. I think what we have to take a look at, what is the mission or the function of the facility. And then also, if it is appropriate to consider a replacement facility for Boston—we need to take a look at the dollars—what would it cost us to do something as opposed to what is currently being projected at the present site.

Mr. **Moakley**. I think the chairman will tell you that the word "modernization" and "refurbishing" goes down a lot easier in the eyes of people than a replacement.

Thank you very much, Ms. Small.

Ms. **Small**. Yes. Thank you.

Mr. **Edgar**. I think also it should be noted for the record, sometimes the replacement idea is the most logical. It doesn't necessarily mean that Government will make the most logical decision. There are all kinds of planning processes, getting on a 5-year plan, getting on and off that 5-year plan, getting it put into the pipeline of when that replacement takes place.

In some instances, it is almost a necessity out of desperation that facilities are 30, 40, 50 years of age, that need replacement, start to get modernized because they are afraid they won't meet that projected need.

One of the questions I am hoping my subcommittee will take seriously concerns the long-term financial obligation of the Federal Government to make sure that when we get to the year 2000 that we have as modern or a more modern veterans health care system in place as possible. And what does the cost of that entail at a time of a $200 billion deficit?

How are we going to do that when you are buying MX missiles, B-1 bombers and neutron bombs, and you have committed yourself to $6 trillion of defense spending, and reduced your tax revenues at the same time. Looking at long-term projected deficits, how are we going to do that when at the same time that is happening, your bridges, your roads, your water and sewer systems are all deteriorating—we have even new highway bridges that are falling into the water, and we have massive need in the older industrial areas of the country to have rehabilitation.

When it comes to a fixed facility, like the veterans facilities, there should be a 5-year, 10-year, 20-year assessment of what those facilities needs are.

I yield to my colleague from Georgia, Dr. Rowland.

Dr. **Rowland**. Thank you, Mr. Chairman.

One brief question to begin, about female veterans. In your prepared statement, Mr. Krajeck, you said that 2.7 percent of your workload now is female veterans. Do you have any idea how many female veterans there are in this area?

Mr. **Krajeck**. We do not have those figures of female veterans in this area.

Dr. **Rowland**. Well, the question was brought about because of whether or not females are utilizing their eligibility such as they could be. That is essentially the reason I asked the question.

Do you have any idea about that?

Mr. KRAJECK. We know that 828 female veterans utilized the facilities during fiscal year 1982. We have a breakdown of the percentage of discharges by age group.

Dr. ROWLAND. Is there a continuing increase in the number of females that are using veterans' facilities?

Mr. KRAJECK. I believe so, yes.

Dr. ROWLAND. Mr. Schuerholz, I am very pleased to hear your enthusiasm about your outpatient clinic. You did mention one thing I have heard often, and that is the frontline people.

No matter how good the medical care is that is provided to the veterans, if they get a bad taste in their mouth when they encounter frontline people, then they go out and say the care was not very good—that is the impression left with them.

Do you find that to be a very great problem here? And what do we need to do to address that problem, to improve that situation?

Mr. SCHUERHOLZ. I don't know really what you could do. I mean, as far as the caliber of people—and I find that the pay of the people, and we have them there for a certain length of time, they do improve and they go up the line, they move right up, they don't stay in these positions long.

Dr. ROWLAND. Is this a point of entry for people who work in the VA?

Mr. SCHUERHOLZ. Not actually. That is not a point of entry. That is not the lowest level we hire. But like I say, we try to stay with them constantly, keeping these things up, particularly if we get complaints from veterans, particularly if they come up to my office, then I find out what the story is.

We try to make sure other than the required—there is a required annual program the medical administration service puts on—it is a canned program, videotape, that is required for each MAS employee to go through this. A lot of that has to do with attitudinal training.

In addition to that, we do have training programs for them constantly in such areas as meeting the public, the latest "may I help you" type program, even answering the phones and these kinds of things and talking to veterans. We try to set the front part coming in where we can give the patient as much privacy as possible without putting blinders or stalls up, and make it a personal kind of thing.

We would love to have our people with smiles on their faces all the time, something like the Disney World people do.

Dr. ROWLAND. But you still find it to be a problem.

Mr. SCHUERHOLZ. No, I don't think it is a problem now. Not with us.

Dr. ROWLAND. Do you have any complaints about the length of time that veterans have to wait before they are seen?

Mr. SCHUERHOLZ. Occasionally there will be some complaints.

Dr. ROWLAND. Mr. Chairman, I am going to have some questions about agent orange and ionizing radiation. I wonder if it might not be appropriate for me to wait for a future witness.

Mr. EDGAR. OK. We will reserve your right to ask those questions.

I am going to ask one now. You mentioned, Mr. Krajeck, that you did some tests for ionizing screening in your opening statement. Congressman Evans asked the question about agent orange screening. I am interested in what kind of screening you are making for the atomic veteran, what is the process they go through?

Dr. **Rowland**. That is my question, Mr. Chairman.

Mr. **Edgar**. You see, I don't ask that of a physician.

Mr. **Krajeck**. First of all, they would come in and make application and identify themselves and then follow through the process that the individual medical centers have established for dealing with that particular complaint.

Mr. **Edgar**. Is that an order from central office that you provide screening for atomic veterans?

Mr. **Krajeck**. Yes.

Ms. **Small**. It was published August 1.

Mr. **Edgar**. So it is new to your system?

Ms. **Small**. In fact, it mandates that we treat these veterans with the same kinds of courtesies and eligibility that we have characteristically given to the POW's. So the clearing process is rather elaborate.

I cannot speak to it from a technical standpoint. Our people in nuclear medicine will be working with MAS people, the medical administration people, to do the PR to get the people aware we are available to do this type of screening.

I am sure Dr. Green, when he comes up to testify, can give you some of the technical aspects of it.

Mr. **Edgar**. We are going to wait for Dr. Green for the technical aspects. But I am just interested in how recent this is in the process, whether or not you use whole body scanners, what are some of the specific tests. I am sure that the medical doctor can give us some of that information.

Let me ask some additional questions.

Could you describe briefly what a regional director does?

Mr. **Krajeck**. We are the extension of Dr. Brown's office in operations. Our responsibility covers a wide area. I think the primary responsibility probably has to do with being familiar with each medical center as thoroughly as possible, having to do with resource allocation, having to do with assisting in establishing priorities for construction projects and other projects, the various categories they fall in.

Also, I would term ourselves a troubleshooter, dealing with disciplinary matters when appropriate. We become essentially a Jack of all trades as far as operations are concerned.

Mr. **Edgar**. Are you able to visit all of the medical facilities in your region in any given year?

Mr. **Krajeck**. Our schedule is such that we would like to visit all our medical facilities at least annually. Sometimes we have special purpose trips in addition to that.

Mr. **Edgar**. What is your most difficult problem in allocating resources given the tightness of the fiscal restraints that we are operating under?

Mr. **Krajeck**. Well, I think everyone that you talk to in top management at each facility could use more resources.

Mr. **Edgar**. In what areas? We are interested in the specifics.

In one region, for example, we found that hospitals were drawing from the general purpose and maintenance and repair budgets to pad their pharmacy budgets because of the increased incidence of use of pharmacies.

Do you find that in this region? Are there some specialized concerns in this region where you have to shift resources that we should be made aware of as a committee?

Mr. **Krajeck**. I don't think that the experience in region 1 is essentially any different than any of the other regions. We have essentially the same needs as far as trying to meet the demands that the veteran has generated. We experience the same increase in drug costs, I think, as every medical center to a varying degree.

As technology increases it creates great demands on resource utilization.

Mr. **Edgar**. Is there a piece of technical medical equipment in either your outpatient clinic or in your hospital, tertiary care facility, or at any one of your regional health care facilities that you have requested from central office that has not been forthcoming because of budget constraints that severely impacts on the quality of care that you can provide in your health facilities?

Mr. **Krajeck**. Not that I am aware of. I will just give you an example of something that happened this past year.

There was some money made available for equipment. What we decided to do with better than half of those dollars was to upgrade the CAT unit at the Boston facility.

Mr. **Edgar**. Do any of the other panelists want to comment about any deficiency in the health care delivery system that you would like to mention for the record as a need in region 1 that you have with your facility?

We talked about the GSA in terms of replacement of the GSA facility. Any other equipment needs?

Mr. **Schuerholz**. No; if I may speak for the clinic—we have some equipment that eventually will be going, X-ray equipment, that costs a lot of money. I think we are holding off until we find out whether we want to stay there or be in a new facility or what. It is not a really pressing need.

You mentioned in your opening statement, I believe to Mr. Krajeck, a lot of millions of dollars to the Boston outpatient clinic. That is not referring to the independent outpatient clinic.

We have no money allocated to our clinic for renovation or what have you. But let me for the record say we are making a good deal of progress with GSA. Three or four months ago they allocated the $225,000 of their jobs bill money to put in our clinic, dress it up, paint it up inside and out, and do fire and safety work, put up new walls, egress areas and so forth.

The contract was just signed out for the work to be done just a few days ago. They are trying to get us somewhere near ready—fire and safetywise, and cosmetically—we have already made some progress on that.

We are having this joint accreditation coming in September 12 and 13. I think that will be pretty close to it.

Mr. **Edgar**. Let me ask just a couple more questions. I apologize to my colleagues for asking so many. But we are trying to get a complete record on these issues.

Do any of your hospitals have special facilities for post-traumatic-stress disability treatment and are any of your hospitals conducting research into post-traumatic-stress disabilities?

Ms. **Small**. I can speak to an aspect of the issue. No. 1, we do not at the Jamaica Plain Hospital have a special unit identified as a post traumatic stress unit, as they do perhaps at Bay Pines, for instance. It is a different rationale.

It is not an omission. It is a way of dealing with post traumatic stress syndrome in our facility.

Our physicians for some time now have been of the posture that the diagnosis is not peculiar to the Vietnam era veteran; it is a diagnosis that covers a broad spectrum of patients. We have a very sophisticated mechanism for dealing with post-traumatic-stress syndrome, both through our outreach programs and our inpatient psychiatric program. But we have elected not to develop a specific unit with that specific designation.

Over the past year, we have had three in-house training sessions for district staff with both Department of Veterans' Benefits, outpatient clinic staff, and they have been interdisciplinary in terms of addressing that diagnosis.

Mr. **Edgar**. What kind of relationship do you have with the outpatient, the Readjustment Counseling Center?

Ms. **Small**. We have two, sir. We have one here in Boston and one in Brighton. The staffs at both of those outreach centers are staffs that intermingle with our staff. Both staffs have participated in the most recent program for post-traumatic stress syndrome, as have both panel members and participants in presenting various aspects of their concerns. I think I can speak to the relationship as being a excellent relationship.

Mr. **Edgar**. Let me ask you a question in the area of security personnel. What problems are you experiencing in the recruitment and retention of security personnel and how would you solve the problem of security personnel?

Mr. **Krajeck**. We are having difficulty in recruiting quality individuals, and also our retention rate leaves much to be desired. If it were for me to propose a solution to the problem we need more attractive salary rates. We also would desire something that could be a more clear pattern of progression of advancement. I think this would help us attract and held better qualified security individuals.

Mr. **Edgar**. OK, let me ask this question. Does the VA contract for hospice care? Apart from the humanitarian benefit, would you envision any long-term savings in utilizing hospices for the terminally ill versus long-term acute care beds that these terminally ill patients may in fact be utilizing?

Mr. **Krajeck**. I am not aware of any contracting for hospice-type services. I think it is one of the issues that that type of hospice approach needs to be explored more thoroughly. And it may be one of the areas in which we should pilot a program in order to find out is it cost effective.

Mr. **Edgar**. Let me ask you a question. In the Boston area yesterday, I witnessed a number of homeless persons. Even though in Massachusetts your unemployment rate is down considerably from what it is in some of the older industrial States of the Northeast and Midwest. We are finding throughout the whole region there are a number of homeless veterans who have not found their way to a domiciliary facility or into a veterans' long-term care facility. They are simply homeless persons on the street.

With the increase in homeless persons, including veterans in major metropolitan areas, does the VA provide any special outreach or services to homless veterans?

Ms. SMALL. The answer specifically to your question is no, I don't think we do, in terms of providing a home, nor do we have a home that is identified other than the DOM.

However, there are many programs currently being considered and hopefully will be developed, such as adult daycare centers and some respite care centers which deal with another issue. But there is another kind of home situation that has a potential for evolving and that is that midway house, halfway house concept, that many of the veterans could flow into.

One of the problems that we often see with the homeless veteran is some of them get into the hospital and want to make the hospital their home. There is also the other group that gets into the hospital and for want of a better term miss their street envionment, their street companions. So we see a transient group of veterans who come in and out of the hospital, who know they are homeless, and feel inadequate in terms of making them want a home or providing a home for them.

I haven't answered your question very well, I am afraid, but it is a very, very difficult issue to address.

Mr. EDGAR. Let me ask you another question. There has been a great deal of press interest in Alzheimer's disease over the last few months. I am interested in treatment and research programs in the region that specifically focus in on that disease.

Mr. KRAJECK. There is an Alzheimer unit up at the Bedford facility which is associated with the division of the GRECC that is located up in Bedford. They are doing a considerable amount of research in this area. The details I am not totally aware of.

Mr. EDGAR. It would be helpful if you could provide for the record some of the research, not only on that disease, but what your early experience is with the GRECC's that you do have in place, and the research you are doing in terms aging veterans.[1] This committee was responsible for putting those in place. We are looking at expansion of them throughout the Nation. We would like to know what your experience is.

Mr. EDGAR. Let me ask one final question which I think I have asked at the other two hearings—at least I know I asked it at the last one. I am not sure that you want to answer fully for us at this point but perhaps for the record.

I would like each of you to think about the year 2000 and the veterans' health care systems and its needs. I would like you to consider what the future of health technology is going to be as well as the future of health needs, both in terms of delivery of service, quantity and quality of that service. What are the innovative, creative approaches that the veterans' health care system ought to be beginning to experiment with.

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[1] See p. 73.

Should we get involved in hospice care, should we get involve in home health care services, should we have relationships with community hospitals. Should we develop freestanding, independent clinics or affiliated clinics that are next to acute care facilities in outlying communities so that we can maximize the resources of the veterans health care facilities, using and sharing equipment with private sector hospitals who might have such equipment and such medical staff to share.

What kinds of approaches in this region would we need to look to if we were not worrying about what next year's annual budget was going to be, and we were going to look at the delivery of services. What kinds of special problems should we be alerted to relating to women veterans, atomic veterans, Vietnam veterans, and their specialized needs? Are there some areas of concern within the health care system that are signs or symbols of health care needs that are emerging that the Veterans' Administration may not be hearing about?

Is the MEDIPP program adequate to looking at the real long-term need, or are the fiscal restraints that are logically put on that with annual budgets and with the election processes that we have in our system of Government going to prohibit the kind of creative thinking for the veterans system?

I guess what I am really asking in this comment, and question is, if this subcommittee were to tackle the larger question of a 5-year, 10-year, 20-year plan for the veterans health care system, and were it to convince this administration or a new administration that over the next 20 years we are going to have to spend *x* number of dollars per year and move the system from *x* number of hospitals, number of outreach clinics, to the following models, what would that health care system look like?

I don't know if you want to tackle that question now, but I would appreciate anything in writing that you might provide.[1] And anyone in the audience who may also have suggestions to that question, I would appreciate their responses as well.

Mr. **Krajeck**. I think we would prefer to put that in writing, after we have had a chance to think of some of the aspects of it.

Now I think I would just respond as to one of the things that we have to put emphasis on is to keep individuals out of hospitals.

Mr. **Edgar**. Keep what?

Mr. **Krajeck**. To keep individuals out of hospitals and develop ambulatory care-type programs or approaches so that people, veterans, are not institutionalized.

Mr. **Edgar**. Any other comments for the record that any of you would like to make at this point?

Ms. **Small**. Just a comment that perhaps in the area of education we would be well to try to disenchant people of the theory that the elderly are always the chronically ill. One knows that in the last year of life that is probably the time when the most dollars are spent relative to medical care, and that we need to be talking for the elderly in terms of acute care, acute episodes of care as well as chronic care.

Mr. **Edgar**. We also have to talk about those who are retiring at age 55, age 60, and age 65, whose life expectancy is no longer in the sixties or in the seventies, but maybe in the eighties, the nineties, or beyond. And the question of leisure time, recreation time, long-term needs that may accrue to the whole veterans system ought to be considered.

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[1] See pp. 78, 83, 157.

Are there any other questions from my colleagues?

I want to thank you for your patience and answers to the questions. We look forward to visiting the outpatient clinic and some of the other specialized services. Our hearings will be a very involved set of hearings over the next couple of months. We do hope that you will look at that last question and give us some of your serious thoughts for the record. You don't have to actually pass those comments through central office, if you have some personal views. It is a dreaming question, a foresight question which I think we have to begin to ask in the veterans' health care system.

Thank you.

Mr. **Krajeck**. Mr. Chairman and members, I would like to thank you for the opportunity to discuss health care to veterans this morning. We appreciate your interest and your support.

Mr. **Edgar**. Thank you.

Mr. **Edgar**. Our next witness is Dr. Green. We are pleased to have you here. We are interested not only in urban veterans' facilities, but in many instances there are small veterans' facilities, rural and remote veterans' facilities that are equally important to focus on.

We appreciate your time in coming to Boston and participating in the hearings. You may proceed.

The full text of your statement will be made part of the record.

STATEMENT OF DR. HOWARD GREEN, CHIEF OF STAFF, VETERANS' ADMINISTRATION MEDICAL CENTER, WHITE RIVER JUNCTION, VT.

Dr. **Green**. Mr. Chairman, members of the committee, I want to thank you for the opportunity to speak.

Speaking about our rural nature, I did get up at 5 o'clock this morning so I could get down here in time. Fortunately, we have a throughway system that permits that.

I represent a hospital that is in the quaint town of White River Junction, Vt., that used to be the railroad center of northern New England and is no longer.

The hospital has 194 beds. We are affiliated with the Dartmouth Medical School, have a turnover rate, 39 house staff, and relatively low cost for delivery of service.

I am here today to express my increasing concern as a physician about our ability to deliver full and quality service to the people who use us.

I think Ms. Small and Mr. Krajeck have covered adequately the nature of our patient population, those people who do not have substantial means, who are putting increasing demands on our hospitals and out-patient clinics because of the economy and because of advancing age and their degree of illness.

Frankly, in the 10 years I have been at White River Junction, I can tell you that the hospitalized population is sicker than it was 10 years ago when I arrived at that hospital.

We are caught with a dilemma. The dilemma is that we can do more for people. Twenty-five years ago, when I was an intern, a cardiac arrest terminated the event. There was no recovery from cardiac arrest.

Nowadays, there is recovery if it occurs under reasonable circumstances.

Cancer therapy has improved dramatically to the point where certain forms of Hodgkins disease have been essentially cured, but the cost of doing that is great.

In addition, surgical therapy of the heart has gone to the point where the costs are just astronomical. Over $2 billion will be spent in the next year in coronary arterial bypass surgery.

My major concern is the continuity of care of our veteran population.

Let me define for you what I consider to be continuity in good medical practice.

If a person comes for care, it is essential that a judgment be made whether or not that individual requires followup or not. If it is a simple episodic thing, the idea of giving a prescription or treating for one episode is all right, but our population is characterized by multiple diseases. Our veteran population is in need of continuity and followup care. We cannot give that care because of the limitation of resources, and we are forced to follow the strict eligibility rules that are set forth.

We cannot follow a nonservice-connected veteran who has been hospitalized for more than 1 year following discharge because of the OPT/NSC provision which limits followup to 1 year.

In addition, in ambulatory care there is a current regulation that allows four visits to obviate the need for hospitalization and then we have to drop the patient. That, in my view, is not good medical care.

As a result, physicians have to behave in a manner to create eligiblity by inappropriately hospitalizing veterans to create that eligibility.

After the 1-year period is up, if a person goes through a 2-day hospital admission, you create the eligibility. We have to do this for prosthetic appliances. That, I submit, is not either economic or wise because hospitals, in themselves, are dangerous places in certain instances.

In the small hospital setting, we do have some unique problems. We have the same functions as a large hospital, but frequently, because of our staffing, we have one person doing the job. If we lose that person, we have to cross-train other people; we then have to go through the mire of the OPM rules, particularly with technical people.

I will give an example of the problem with OPM later.

Frequently we have one physician covering a specialty. The rules work against us in creating part-time slots because the pay of these physicians is not on a prorated basis compared to the full-time physician.

In a rural environment, the oft reported private sector rewards of part-time status are not true. The recruitment of part-time physicians even if we did have the budget, is not easy.

We have depleted training and education funds. Our hospitals are more sophisticated. The need for constant updating as medical care and technology goes on a logarithmic curve in its progress, is such that we do not have sufficient funds to train our people.

If my recollection serves me correctly, the Veterans' Administration ranked 26th out of 28 Federal agencies in per capita expenditure for training and education.

In a highly technical arena, that is too low.

I would like to finish by talking about some problems that we have with the OPM qualification standards.

We had a position of a hospital lab microbiologist open in 1977. That position was not filled until 21 months later in 1979 because of the problems with qualification standards.

We went through a misadventure by hiring somebody who had had minimal training in microbiology, tried training her for 4 months and it didn't work out. So it took us 21 months to fill a position in microbiology in a hospital. In a one-horse operation where there was only one technician available—and that technician has to have time off including leave and everything else—this is not acceptable.

So this has been a real problem.

I would say to you that resource limitations are preventing us from delivering the quality of care that I feel is required for our veteran population. The veteran who happens to be taking the brunt of this at the current time, Mr. Edgar, is the nonservice connected veteran without special eligibility.

That concludes my statement.

[The prepared statement of Dr. Green appears on p. 69.]

Mr. **Edgar**. Thank you very much. We really appreciate your statement. You raise some points which are really important to focus.

Let me just ask you a couple of brief questions.

I will yield to my colleagues and come back with a couple of additional questions.

You talk about the sicker patient that you see today than you saw 10 years ago. Can you describe what you mean by that, and what kinds of concerns are related in that statement?

Dr. **Green**. Yes. It is interesting. In many ways our sicker patient is created by our medical expertise. Let me give you an example.

I am going to go back to our cancer therapy and to our cardiac programs.

I mentioned 25 years ago a cardiac arrest terminated the event. In short, cardiac resuscitation wasn't well known. The maneuvers that one went through were short and to the point. It was a matter that there was no real after care or follow-up. The fact we can do these things and make patients survive creates sicker patients with higher need for technology.

The number of drugs available for treating cancer patients 25 years ago I could count on five fingers.

Now I could not count them if I took my shoes off.

The point is, in the process of treating patients, they are sicker because they do not die from their disease, their life is prolonged, and in many cases usefully. In addition, as our population gets older, not only the aging effects, but the effects of arteriosclerosis, heart disease, all of the diseases that we encounter from use of alcohol and cigarettes make our patient population sicker.

In addition, the delivery of health care has improved and is more efficient. Therefore, the patients that we would have hospitalized 10 years ago are now handled on an out-patient basis and therefore it winnows out the sicker patients to the hospital.

Mr. **Edgar.** You mentioned when you talked about limited resources, you quickly went over a couple of letters of abbreviation—OTRN was what I heard. I don't think that is exactly the listing. For those of us who are of a primitive mind, I wonder if you can go back and recover for us the exact term?

Dr. **Green.** As I recall, the acronyms I used were OPT/NSC. That is outpatient care, nonservice connected, for the record, and OPC ambulatory care, or OPT-AMB. Those were the two. The ambulatory care regulation was defined because of the rule that a veteran could be seen to obviate the need for hospital care.

The segment created in the regulations is ambulatory care, OPT/ambulatory care for the nonservice connected veteran.

Mr. **Edgar.** You talked about problems with OPM and the regulations and the delay in hiring a specific staff person. That is a real critical problem that we are finding throughout the VA. I understand that White River Junction has a staff ratio of 2.5 to 1. Is that correct?

Dr. **Green.** That is correct.

Mr. **Edgar.** That particular ratio is above the national VA average. If you are enjoying such a high ratio, how can you have problems meeting medical demands for your veterans?

Dr. **Green.** I would like to address what the staffing ratio means in answering your question.

The core staffing ratio is a static number. It is derived by taking the number of beds that are occupied over the average daily census and dividing that into the number of people assigned to those beds.

So, for example, if you have a hospital with 50 beds occupied and 100 people assigned to that, the core staffing ratio is a 100 divided by 50, or 2 to 1.

Let me give you two separate situations to clarify that in terms of my hospital versus another one.

Let us say you have in the one instance a hospital with 200 beds and 500 people assigned that has an average length of stay of 10 days. Hospital B, or hospital 2, has a 400-bed occupancy and 700 people assigned, but it has an average length of stay of 20 days.

The first hospital has a core staffing ratio of 2.5 to 1. The second hospital has a core staffing ratio of 1.75 to 1.

Let us assume that the patient populations being served are the same, in short, a general medical and surgical hospital with identical patient populations. Therefore, we are comparing apples to apples and not apples to oranges.

If the hospital with the 20-day length of stay reduced its length of stay to 10 days, it would have 200 occupied beds and a 3.5 staffing ratio without one change in personnel, but an increase in their performance.

The White River Junction hospital has an average length of 13 days length of stay, which, for this system, considering that it has general medical, surgical and psychiatric patients, is really quite good.

We have a very high turnover rate and low cost. What I am saying is, our people are performing very well. We are keeping our length of stay down and we are not filling beds unnecessarily.

I think in my example I have shown you that without any change in personnel, the core staffing ratio can shift from 1.75 to 3.5 without doing a thing except reducing the length of stay.

Mr. **Edgar**. Thank you. That illustration is very helpful.

Is your hospital considered the community hospital of the residents who live in the area that are veterans?

Dr. **Green**. Yes, it is very much so. We enjoy a very good relationship with our veteran population. It is a community hospital for Vermont and portions of New Hampshire.

Mr. **Edgar**. How close are the other hospitals in the area?

Dr. **Green**. The closest hospital is Manchester, which is 70 miles away. Boston is 130 miles, plus some problems with traffic. North Hampton hospital is 2 hours south, or roughly 100 miles.

Providence Hospital, as you know, is a greater distance than that, and Togus, equally.

Mr. **Edgar**. Do you have any ability to take accident victims who are nonveterans, health problems in that area, for temporary——

Dr. **Green**. There is no question that we do.

Mr. Edgar, it is a matter of assessing the degree of injury as beyond our capabilities, 5 miles up the road is a class A emergency room in the Mary Hitchcock Hospital, which is Dartmouth's affiliated hospital.

We would send severe head injuries or other major trauma which involves neurosurgery to that hospital.

We are capable, because of our residency staffs and the quality of our staff, of handling most trauma with the exception of neurosurgical trauma.

Mr. **Edgar**. Could you give us some specific examples of limiting of services at White River Junction due to funding constraints?

Dr. **Green**. I would like to recount for you several of these and give you specific examples, but I would also like to put the caveat in the record that the decisions to do this were strictly internal management decisions based on resources.

They were not directed from the outside. In short, what I am doing is taking responsibility with my hospital director for the decisions that were made because of reduced resources.

The Leonard formula for CAT scanning would say our hospital should do a thousand CAT scans a year. Up to this point this year, we have done 236 because of very strict controls on CAT scan, and because of shortage of budget to purchase these scans. The shifting of budget to do these scans would necessarily be reducing services elsewhere, and that has been a management judgment.

We have had to reduce usage of specialized laboratory tests because of budget. We have had to delay sending these out, particularly as quarters come to a close.

We have delayed prosthesis procurement. Patients have been held in the nursing home care unit or hospital inappropriately long because of this. We have reduced our OR schedule in orthopedic surgery so that the first appointment is November 15 for a hip replacement at this point because of the cost of hip prosthesis.

We have had to stick very closely to the strict eligibility criteria. Supply and pharmacy purchases have been delayed because of restrictions in budget, and we have been unable to mandate certain programs that are indicated in circulars, such as the Total Parenteral Nutrition Committee. We have had to take strong positions to our physicians about prescription drugs.

Those are some of the actions we have had to take. This is an internal management decision, not a reflection of what we have been told to do.

Mr. **Edgar**. Thank you very much.

Ms. Kaptur.

Ms. **Kaptur**. Yes.

Dr. Green, thank you for excellent testimony.

I wanted to ask you a question that doctors in my community who don't work for VA hospitals have asked me.

Maybe you can help me answer their questions. They said to me, "Marcy, you know, veterans hospitals are not as efficiently run as private sector hospitals."

And when you talk to your compatriots in the medical profession, you must have heard that, or heard comments of doctors who used to work for VA and don't work for VA any more, and they have all these stories to tell.

If you were in my position and attempting to ascertain to what extent VA hospital care is inefficient or efficient as compared to private sector hospital care, how would you go about answering that question?

What factor would you look at?

Dr. **Green**. Congresswoman, I have heard that comment from some of my close friends who are not in the Veterans' Administration. Currently I don't think you could prove the point one way or the other. The reason I don't think you can prove it is because I don't think you have appropriate data systems with which to make that conclusion.

Let me give you an example of what I mean.

The private sector, because of the payment mechanism, has been forced to develop what I call resource tracking systems.

Let's define resources as human resources and inanimate resources. In short, they can generate a bill. They can track what would be considered the variable costs of hospital care which are physician services and the inanimate resources devoted to a given patient. This can also be applied to a given diagnosis, because each patient in the end carries a diagnosis.

It is very easy for the private sector to develop a cost or charge for the delivery of that variable service.

The other component of health care is what I call the fixed component cost because it is fixed over at least a period of time and that is hospital care. I am not convinced that we have adequate mechanism for developing true costing in our system for the hospital component.

The answer to the question is that we have to look very carefully if we wish to prove we are less costly. Marrying our data systems to mirror the private sector is critical. Unless we do that, you will never be able to get an answer to the question.

We can get some cut at that answer by the current resource allocation methodology now being put in place in the VA. We are working with the so-called diagnostic-related group classification of disease.

If you know the total resource being put into anything, and have a relative weighted scale for the diagnostic-related group compared to the private sector costs, you can derive a first cut of what your costs are for each diagnostic-related group.

But you cannot get very specific. I think it is a data system problem.

Mr. **Edgar**. If the gentlewoman would yield, it is not an unmanageable data problem, is it?

Dr. **Green**. No, sir. As a matter of fact, the software is in the private sector, the private sector is extremely sophisticated in using this. It could be implemented in this agency.

Mr. **Edgar**. Probably hook it up to my home computer. My 14-year-old probably could handle the program management of it.

Dr. **Green**. Mr. Edgar, I hope not.

Mr. **Edgar**. I am just teasing.

Dr. **Rowland**. Would the gentlelady yield on that point?

I have heard this argument over the years too. At one time I thought that was probably the case, having been in private practice for many years.

Perhaps that was true. When we didn't have the highly sophisticated diagnostic and treatment modalities we now have, but in the private sector now medical care is getting increasingly expensive, and I think it has exceeded by far, for example, what it costs in the private sector to do coronary artery bypass surgery as compared to what it would cost in the VA.

All of the facilities are in place in the VA and the cost has not gone up that much insofar as personnel is concerned. Looking at it from that standpoint, Dr. Green, do you think that might be true, that the Veterans' Administration may be becoming more efficient and less expensive in some areas than the private sector?

Dr. **Green**. I think your intuition, Dr. Rowland, is correct. I like to believe that, given the management systems we can put in place, that we can run more efficiently than the private sector, but I cannot prove it, and this is where the issue hangs.

I would like to be given the chance to prove that point because I think it is true.

Dr. **Rowland**. Thank you.

Ms. **Kaptur**. Thank you, Mr. Chairman.

Mr. **Edgar**. I attempted to ask a question about the decentralized computerized system we have been arguing over with the VA. I don't know if you have a comment pro or con about that.

I don't mean to open that debate again, but the decision, I think, has gone to decentralized computer operation.

Do you think that is a good thing?

Dr. **Green**. Yes, sir, I do. I think that that was an extremely wise decision on the part of the Congress.

Centralizing something as changeable as the computer field I think is a big mistake. The weight of the bureaucracy and the decisionmaking in the bureaucracy is not fast enough to keep up with it.

I can only say that I think that there has been a massive step forward by planning to put ADP help into this health care system. I would applaud Congress for making that decision.

Mr. **Edgar**. I almost wanted to underscore your words about applauding Congress because we get so little applause in most of what we do.

Dr. **Green**. You guys work hard too.

Mr. **Edgar**. Congressman Evans.

Mr. **Evans**. I appreciate many of your comments, since I represent a largely rural area. We have one out patient clinic just outside my district which is the closest thing to serving most of the needs of the veterans in my district.

One thing that does concern me though, do you anywhere in your area have a veterans' center?

Dr. **Green**. Yes, sir, we have two veterans' centers, Mr. Evans. We were actually the first to open one in White River. We have one very close to our hospital in White River Junction and one in Williston, which is up near Burlington.

Our chief of psychiatry, Matt Friedman, has a wife who was a veteran in Vietnam. Matt was treating delayed stress syndrome among Vietnam veterans long before we thought of the name. He has been really the sparkplug for our vet center development in Vermont. It has worked extremely well in Vermont. The relationships with the hospital are very good. We have never had any real strife.

Mr. **Evans**. Do you have any specific treatment units at your hospital for post-traumatic stress disorder?

Dr. **Green**. No; it is just part of Matt's interest in the psychiatric care of veterans.

In a small hospital, you can put names on programs, but it is relatively meaningless because you could have more programs than people.

Matt has an ongoing concern about delayed stress and has recognized it not only in Vietnam veterans, but in all veterans.

Mr. **Evans**. Thank you.

Mr. **Edgar**. Do you think we ought to continue the counseling centers for a few additional years until we fully assess the ability of those centers to reach those veterans who would not normally come into the traditional veterans' health care system?

Dr. **Green**. Speaking only to my knowledge of what is happening in Vermont, I would say that they have been a very positive influence for the Vietnam veteran and I agree with your statement that they should be continued until we can assess where we are, particularly in the State of Vermont.

I do not have enough knowledge of their activities elsewhere to comment intelligently otherwise.

Mr. **Edgar**. Thank you.

Dr. Rowland.

Dr. **Rowland**. Thank you, Mr. Chairman.

I want to ask some questions about agent orange. Have you had any experience with that in your hospital?

Dr. Green. We obviously have a program as mandated by central office for handling the agent orange veteran. We are very careful in our counseling and our recordkeeping in trying to get these people in.

We have the advantage, Dr. Rowland, in being a center which includes the Department of Veterans' benefit functions.

Therefore, our information services are widespread, and we get the word out among the population.

Also our Vietnam vet centers have really led the way in leading people with agent orange exposure to the hospital.

We also have 1 of the 10 research protocols for agent orange centered at the White River hospital headed by Dr. Herbert Bankowsky, a world expert in porphyrin metabolism.

One of the effects of the TCDD is to interrupt the biosynthesis of hemoglobin and create porphyrin.

We have an intense interest in the outcome of the agent orange story and are actively involved in investigating it.

Dr. Rowland. You know that there is considerable debate now all over as to how much health problems have been caused by agent orange. We recently had a hearing by the Investigation and Oversight Subcommittee of the Public Works Committee, and we had two physicians on that panel, one of whom felt that agent orange was causing very little difficulty in health problems and the other felt it was causing a great deal of problems, largely because it is photosensitive and doesn't last very long after it is exposed to the sunlight.

But, what are you finding in the VA and how are you going about finding in the VA the relationship between health problems people say they are having because of agent orange and what you might interpret as problems not being caused by agent orange that are thought to be?

Dr. Green. That is a very tough question for me to handle but I will do it the best I can.

People who have been exposed to agent orange are frightened and rightfully so because it is probably—it is the most toxic chemical compound that man has currently worked with. There are some serious questions about how it operates to affect a patient, as you alluded to. We clearly know of the documentary evidence of transient effects on porphyrin metabolism, but at this time, at least in my judgment, we do not have the final answer on what the long-term effects might be, and I suspect if there is an answer agent orange will be shown to have long-term effects that are not clearly delineated at this point.

Therefore, the physician is placed in a dilemma. He is placed in an information vacuum about long-term effects.

If you take a look at these classes of drugs, you will find that one of the things that one worries about is the long-term problem with mutagenesis and cancer. The same with ionizing radiation. Knowing that it attacks, at least causes transient effects in porphyrin metabolism, one could think there might be something wrong with the liver or in the blood-forming organisms. But it is very difficult to put a judgment call on something you don't know about because you could be equally right or equally wrong.

If somebody comes into my hospital, say, with a psychiatric program, exposed to agent orange, it is very difficult for me or any physician to make a judgment of whether it was related or not.

Clearly if he comes in with a broken leg that is an absolute, I cannot attribute to agent orange.

At the current time we are in a dilemma. The physicians will generally tend to make a judgment that it was not caused by agent orange unless there is evidence to support a contrary view.

I am sorry I cannot give you a more definitive answer, Dr. Rowland, but that is the best I can do.

Dr. **Rowland**. That is the answer I usually get and that is also the answer I would give were I in a similar position.

You mentioned ionizing radiation. Have you had much experience with veterans who are complaining with problems relative to ionizing radiation and are the techniques that you are using to try to substantiate that invasive or are you using mostly noninvasive techniques at this time?

Dr. **Green**. No, I do not have a great deal of experience with the veteran population complaining of ionizing radiation in White River Junction.

I have a considerable experience with ionizing radiation because I was a submarine medical officer in Admiral Rickover's program and rode the first Polaris missile submarine for 2 years, and went through an extensive program of training in reactor physics, and so forth, in that process.

The techniques we are currently using are not invasive. We do not feel at this time that unless you can find something through your noninvasive routes it is justified to go to invasive techniques.

Dr. **Rowland**. Thank you for those answers. I want to ask a question that is more philosophical now, I suppose.

You mentioned earlier the patients we are having now are caused by our own expertise—the sicker patients.

Dr. **Green**. In part, sir.

Dr. **Rowland**. Well, we are helping people to live longer, and we, of course, know that an aging population is the one that requires the most medical care. I believe this is what you were referring to.

Dr. **Green**. Yes.

Dr. **Rowland**. Not everyone can have a liver transplant and not everyone can have coronary artery bypass surgey, and not everyone can have all of the wonderful things that have been developed in medicine.

My question is, How do we go about addressing that in the future as we find more and more people requiring that type of care?

Dr. **Green**. You place probably the greatest moral dilemma of our century at my doorstep.

Dr. **Rowland**. I apologize for my question.

Dr. **Green**. The problem that I have is, as a physician, I cannot take any other position than that if there is availability to promote useful life, it should be applied to our patient population.

I am also a manager, and I realize there is a limit to our resources.

My answer to you on that has to be that the physician has to behave in the way he was trained. He has to represent the best interests of his patient It is a societal decision what resource is to be put behind that.

I think Mr. Edgar mentioned the issue of missiles and bombs and everything else, and I think it is a matter of prioritization of our national resources. That decision cannot be made by physicians. It can only be recommended by physicians for the decision of the society at large.

The dilemma that physicians are in now is that there is no strong societal direction, and physicians have to behave in the way they are trained in representing the patient.

I don't have an answer.

Dr. **Rowland**. Thank you, Mr. Chairman. I thank my colleague very much for being here this morning.

Mr. **Edgar**. Dr. Green, before you leave the table, I don't have any additional questions, but I think in the quality of Dr. Rowland's questions, and the quality of your response, you have justified whatever expense to you or to the VA or to anyone traveling the distance that you traveled to bring your testimony.

I asked an earlier question about the future of health care within the VA system. I would particularly think that those of you who operate and develop your medicine skills in remote areas or in areas that are smaller in size than metropolitan areas have to help us to determine how we can use the limited resources of Government in unique and positive ways 5 years, 10 years, 20 years out.

I hope that you might visit with your medical staff and with some of the administrators of your health care facilities and some of the people in the private sector in your area and develop an answer—it wouldn't have to be a long answer—to that long question that I asked earlier, because it is our hope that we can put a report out that does look at some innovative ideas, some pilot programs, some techniques of delivery of service that may be new and different for the VA, but may in fact utilize the limited resources in a more creative way.

I am particularly concerned, as is Lane Evans and others who came from rural areas and areas that do not have one of the acute care facilities, that we provide for those veterans who happen to live in remote areas. So any kind of advice or coment, that you can provide us would be very helpful.

Dr. **Green**. You will receive an answer. I have some ideas. I will discuss it with my colleagues and you will be hearing from me.

Mr. **Edgar**. OK. We are probably going to end our field hearings early in December of this year and be developing our report in December, January, February, in our legislative initiatives for the next year and succeeding Congresses, and it is my hope that we can put together a compendium of the exciting ideas that we are discovering, both within and without the VA, about that time.

It would be helpful if we could receive your comments probably by the end of September.

Dr. **Green**. Yes, sir. I would be glad to do that. I want to thank you and the committee for its forbearance. Thank you.

Mr. **Edgar**. Thank you very much.

Mr. **Edgar**. Our next witness will be Mr. Paul Camacho, executive director, Commonwealth of Massachusetts Special Commission on the Concerns of Vietnam Veterans.

Paul, I want to thank you for your patience this morning in listening to our other witnesses, as in any of these hearings, when you have long-winded chairmen with lots of questions that tend to go longer than you anticipated.

We invite you to summarize, if you could.

We would like to hear from you at this point.

STATEMENT OF PAUL CAMACHO, EXECUTIVE DIRECTOR, COMMONWEALTH OF MASSACHUSETTS SPECIAL COMMISSION ON THE CONCERNS OF VIETNAM VETERANS

Mr. **Camacho**. I want to thank you in behalf of the Commonwealth's Special Commission and Senator Doris, our Chairman, for the opportunity to testify today.

I made some notes with the recording I will give to your staff person, and I will have these notes typed up and sent to you. We have been very busy following the Federal Job Training Partnership Act, which is crucial for the Vietnam veterans up here.

May I first say that we understand and fully support the move to geriatric care. This is an obvious necessity. However, I would be less than frank if I did not express to you the concern that many Vietnam era veterans have, and that is that they fear that a zero sum game is going to be set up here which pits the older generation of veterans in terms of their needs and overall budget allocations and program orientation against what we are going to need.

We do not want that kind of dichotomy to be set up.

We fully support our fathers, our uncles, in their needs from the Veterans' Administration.

While I will try to stay to health care issues, I must point out that the nature of the problems faced by Vietnam veterans do not lend themselves to such clearcut categorization. Our problems tend to overlap. I will attempt to point out how health issues are directly related to several of the tangential topics that I must touch on.

As you may be aware, the function of this Special Commission on the Concerns of Vietnam Veterans involves a unique mandate. That is, in contrast to the other 27 special commissions across the country, ours is a full commission.

We cover the whole range of issues, and we might say that they go from the very particular, to the nature of the war and the homecoming, to very staple concerns of all of us—jobs, education, housing, health care—vascillates between being the very special issue, such as is the case with agent orange, and PTSD, to very normal health care problems common to any veteran—gunshot wounds—disabilities of that nature.

Now, first understand that the issues here of concern are threefold that I should cover today. These issues would be PTSD, agent orange, and the needs of women.

Now, the latter concern, that of women, on terms of their obvious different health care needs, has already been mentioned at this hearing, and thus I will touch on the subject only in connection with the two primary subjects of interest facing Vietnam veterans immediately.

That is PTSD and agent orange.

PTSD is perhaps the most important issue at hand, and I say this not to demote the impact of agent orange, but, rather, to focus on PTSD because in a very practical sense the problem here has the most impact. That is the condition of PTSD penetrates into all those other staple problems—employment, attitudes, jobs, perceptions—all those concerns, and here, this has been pointed out I might say, in our interim report, Senate 1824, which I have two copies of—and I want you to have both of these. I will give them to you.

Mr. **Edgar**. Without objection they will be made a part of the file of this hearing.[1]

Mr. **Camacho**. Very good, sir. Now, I assume that you know that these problems overlap. And I assume that at least somewhat that the condition of PTSD and the problems of Vietnam veterans are familiar to all. That is why I want to move to specific points.

One, the Veterans Outreach Center. This Commission has written a number of letters, on the one hand, kind of criticizing the Veterans' Administration about how they have handled the Veterans Outreach Center, but indicating to them that we totally support the storefront outreach center concept. That is crucial to the Vietnam veterans. That is not a question at all.

We support the 3-year extension easily, and we would like to triple the number of vet centers across this country. We hope to push that through our friends in the legislature. Vietnam vets have two good friends I can tell you immediately—the Speaker of the House, Thomas O'Neill, Jr., and Joseph Moakley. There is no doubt. We have help from all in our congressional delegation. So we hope to push this.

Now, the vet centers deal with these tangential issues. For example, we had an employment person in the 480 Tremont Street place. He was pulled by DES. We wrote letters to have him put back in there. Part of the problem of stress is the unemployment problem. Stress eats in all these issues, and that is unique to the homecoming, and job placement, and counseling, and discharge upgrade. So the veterans centers not only need to be expanded; they need autonomy—let us face that. Autonomy was not there in the beginning. The program was not there in the beginning.

In reality the program was a result of two things. The carrot was the DAV Outreach program, and the stick was Roland Mora's National U.S. Conference of Mayors' DOL plan to fund that National League of Cities program. And then he was pushed out under the Carter administration. You must be familiar with that. So that carrot and that stick forced the VA into seeing the obvious, that they needed outreach.

The veterans centers are the most effective way to deal with the initial stress cases as intake facilities, because these fellows, the hard to reach veteran, are simply not going to go to a standard VA hospital. They will not. The people you see at 480 Tremont Street, the people you see at the Brockton Outreach Center, and the people you see in Springfield Outreach Center and in the private outreach centers started by wives of Vietnam veterans who had committed suicide or had unbelievable problems, such as Linda Dargis' operation up in Fitchburg—they see veterans and do counseling for women and wives. And that is where the needs of women can come in. You should consider the needs of the wives of Vietnam vets in this.

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[1] See p. 86.

Later, the veteran on his own, after he has gone through the outreach kind of thing, is able to seek modes of treatment such as one offered at the Court Street Clinic. We have heard rumors back and forth that Court Street is going to be demolished. We want Court Street to stay around—whether it has to be relocated or whatever. It has to stay here. As the gentleman who testified before said, that is a very convenient accessible place, and that is the most important factor.

Then they can seek the people such as Vanderpol, Sara Haley, Dr. Welow, Dr. Brown, competent people they have up in Court Street. But initially the veteran is not ready until he gets up there.

Second, the Commission supports fully the expansion of the pilot stress ward concept such as now functioning in the Northampton VA under the direction of Dr. William Botelli. This entire program should be instituted across the VA system.

Now, we understand the security difficulties here. This shows up in connection with the Vietnam vets who in part because of PTSD become involved in the criminal justice system. I will get back again to the need for the stress thing.

We request, in fact, that the VA increase the services here, that is, to veterans who are incarcerated. They need PTSD counseling, AO counseling and screening, and they need the standard physical disability care. There exists this bureaucratic snafu whereby the Department of Corrections in Massachusetts cannot bring a fellow into Jamaica Plain. The guard is armed. VA says no. Corrections is not going to let this guy go. The VA doesn't want to take the responsibility for him. And there is a blockage here.

We cannot get Corrections to reach some kind of agreement with the VA. We need this agreement, because you have guys with serious disabilities up there, mental and physical disabilities, at Walpole, at Norfolk, and this exists across the country. I want to just point out that the population is roughly 15 percent. The incarcerated male population, since 1968 to present, I would wager—and there are enough studies, GAO study, study out in Pennsylvania, the Department of Corrections study from Massachusetts—that 15 percent of the male adult prison population at State and Federal institutions are Vietnam vets. That points out a whole range of problems there. And I tell you, you cannot divorce that from stress and from the problems of the homecoming.

And now we get back to the point which I must take issue with, Ms. Small's statements, about they haven't had a PTSD special ward at Jamaica Plain because this is a familiar product. I do not agree. and I don't think psychiatrists would agree. The Psychiatrists Association, the official association recognizes it.

Let me point out something about Vietnam. PTSD is three things. One is common to all war—the brutal massacre in the sense of the word that all war is. Hue City was a mini-Stalingrad for 3 weeks in hot weather. The Battle of the Bulge was a vicious campaign. Tarawa, Pork Chop Hill or Heartbreak Ridge were vicious campaigns. That kind of combat stress is common to all veterans. But guerrilla warfare is not common.

I am talking about civilian guerrilla warfare. Possibly you can talk about the Huk rebellion. But this is the first time we are really talking about civilian guerrilla warfare. If you are a soldier out there facing 14-year-old kids, 11-year-old kids walking around the perimeters of any fire base with a water buffalo and marking positions, you know what they are doing, they are setting you up for a kill. And what are you going to do? Are you going to get involved in shooting them. You cannot tell the difference between a civilian and a VC and NVA unless you were very lucky. And that luck saved your life. That is the point of guerrilla warfare.

How did Mai Lai occur? That was murder, and he is guilty of murder. But how did that set up, what was the process of how we conducted that war? How was that war administrated that set that up? McNamara's managerial system. No regimental system existed in Vietnam. It existed in World War II, and existed in Korea. But there was no regimental system per se. Officers rotated every 4 months, people rotated in 13 months. The troops did not know each other. By the time of the end of your tour you were lucky if you knew half a dozen people you could really count on and knew.

That brings us to the second factor, the homecoming. You tell me what war existed where we were spit on in this country when we came home? That is not just my personal story. That is the personal story of thousands of veterans from the Commonwealth of Massachusetts. We did a survey on this Commission, sent out 158,909 questionnaires, to the Vietnam era vets. We got 21,000 responses, clean them off to make them so that they filled out the questionnaire properly, and we got 16,500 clean responses. Over 3,500 to approximately 5,000 of those questionnaires have long letters attached to them, complaining about agent orange, about stress, about the homecoming.

So 14 years have passed and you are not welcomed into the system. We are just now breaking through. And what was the breaking point? A fortuitious event in history, the homecoming of the Iranian hostages who pointed the finger at everybody right down there at West Point and here in Massachusetts and said, "You ripped off"—that was the phrase used—"You ripped off the Vietnam vets."

Then social and political conditions have changed and we have been trying to organize as Vietnam vets associations, and then this Commission was able to get into place and suddenly all these agent orange commissions have suddenly started. So there is a change, and I am happy for that change.

That is the problem of stress, and that is why I disagree. You need a stress ward. Two different factors. Let me repeat. Guerrilla war, we had not seen before. Real guerrilla war. And two, the homecoming phenomenon, which everybody seems to want to forget around here.

Now, let us move to agent orange. The fact is with agent orange we must acknowledge the obvious, that this is a real settlement of a political question. This is a political matter. That dioxin is poison is obvious. That we were all affected is simply a matter of commonsense. Again, this Commission held hearings on agent orange. When the VA contracted a biopsy study and when that pilot study out of Nebraska showed some definitive results, the followup, the full-blown study was canceled. Then it all sat down. Then there were suits and countersuits and Dow, Monsanto, Hercules, and Love Canals, and everybody began tying all this stuff in together.

Now, the VA current AO screening program is a very disenchanting experience. Other than a glorified physical, it could not possibly prove anything. So you have Vietnam vets going in and this Commission has had eight public hearings and five special hearings on particular issues. In the eight public hearings everybody said the same thing. Not only is the screening ridiculous in the sense it is just a glorified health exam, but it is administered differently depending on which hospital and which doctor you go to. It is not even standardized. That is the testimony that we got from at least 60 veterans at each of the public hearings we held regionally, eight public hearings altogether. That was the true population of the hearings.

And then the special hearings were a very different matter. Now, we have questions as to what this VA study on agent orange that they are talking about is going to do. We are getting mixed signals up here. As for the Daschle bill, the consensus of the Vietnam veterans community here is that it should be passed. We would, the Commission and the Vietnam vets, all like to see a stronger bill. However, it doesn't seem possible at this time. The Commission supports the Daschle bill.

This Commission through its chairman, Senator Doris, secured $325,000 for our own little AO study. Obviously that is not going to take you far. So we hope to settle at least one point and that is a kind of registration of families who have children where the children have mild to severe birth defects.

It just seems unusual that we get—I had—especially when the questionnaire went out, we got 350 calls a day for 3 weeks in our office, myself as the executive director and Carmen Colon, my executive secretary, who tried to field all these things. Multiple calls about agent orange. Wives crying over the phone. Is the rate of birth defects among the children of Vietnam vets larger or smaller than that for the standard population? If we get some numbers here—I am not saying $325,000 is going to give us a definitive, enable us to produce a true methodological, medically scientific proven study here. But I want to get a ballpark on this. And if I can come back to you and say I have 5,000, 6,700, 8,000 of the vets we contacted and everyone of them has a child with mild to severe birth defects—the fear is unbelievable. I hear it every day: "My son is epileptic." "My son has a growth in the inner ear." "My daughter almost died this year." "Can I attribute it to agent orange or not?" This story can be repeated, I say to you, a thousandfold in this State alone. So that panic is across the country. And we need some answers.

Now, why doesn't the VA take on this responsibility. Let's not kid ourselves. The Vendom Corporation dumped agent orange—when Dow and Hercules bumped them out of competition for producing that stuff for the war, they sold it to vendors outside of the military field, they in turn spread it on roads—that place is called Times Beach, all the people were moved out. The town of Norwood had a pollution problem of PCP's, in 3 days flat they are testing everybody there. All right?

Massachusetts has water problems. The country has problems. The point is that agent orange is like the tip of an iceberg of the whole chemical waste, pollution water problem issue in this country and around the world. That is the point.

We are talking about billions of dollars here. Everybody knows this thing. The Ranchhand study. On commonsense I would criticize it. All right. Everybody is an expert. There are so many experts coming out with a study pro, there are as many experts with a study con. Who did they test? Pilots. I am an ex-infantry sergeant from the Marine Corps. Pilots got out of the o-club, into the plane, drove the plane, landed the plane, went back to the club. Unless they got shot down in which case they had serious problems, they didn't have to go through it. They didn't load agent orange.

Kids were mixing that stuff with canoe paddles in 50 gallon drums. That stuff was sprayed everywhere. Infantry troops in the DMZ, and I was in the DMZ with the 9th Marines, we walked through that stuff, that stuff sits in the top 2 inches of soil. We sat in it. We had it in our faces. We crawled in it. Ate food in it. If you have ever been in the infantry, you know any infantry is the same.

All of a sudden what is different is we are talking about a kind of chemical warfare here. Besides the fact that the NVA was spraying—we got gassed. There was gas used. We used tear gas.

Everybody knows the war was a dirty vicious little campaign. So suffice it to say we must get back to the point. The issue of agent orange is a political question. Therefore we recommend, the Commision recommends that the VA design an accurate screening program. That the money be made available. If it just costs too much money to do a biopsy study, let the VA do a family study, such as the one the Commission is going to do. It is that—sampling the families, and just catalog them. Nothing more—if nothing more than that, you are going to get some points.

Mr. Edgar. If the gentleman would yield for a moment. We do have some pressures of time. We do want to get to see some of the outreach clinics. Your statement is a good one, and one that is articulately given, and I think has made an impact in terms of post-traumatic stress disorder and the issue of agent orange. I wonder if you could summarize.

Mr. Camacho. We want health care concerns even vaguely attributable to AO taken care of. We suggest in the next legislative year you consider a more comprehensive bill than the Daschle bill, and more legislation for possible compensation.

In summary, increase the veteran centers threefold, provide them with more functional autonomy.

Two, boost the stress ward program, that such as operates at Northampton VA, across the VA system. Provide VA services for incarcerated vets. Do not deny them. Improve the screening process for agent orange, and check on the standardization. Help pass the Daschle bill as a half-loaf door opener. In the next legislative year pass a more comprehensive health care component.

You asked about the future, sir. We are all cancer victims. I can guarantee you the Vietnam vets are. You are going to have a cancer care problem there. At least propose a piece of comprehensive compensation legislation. And, above all, get that VA AO study moving.

On behalf of the Commission, Senator Doris, and the 267,000 Vietnam vets in Massachusetts, I thank you.

Mr. **Edgar**. Thank you very much.

We do have some specific questions we would like to address to you. I would like to comment on a couple of things you have said. One of the things, I think your history is right, that the early storefront counseling centers were not managed as well as hopefully they are becoming managed.

I understand your concern about autonomy. I am sure you realize the fact that there were Members of Congress in both the House and Senate, and particularly people within the administration and within the VA, who did not want the storefront centers in the first place. I happened, prior to coming to Congress, to have run a service called the Peoples Emergency Center in the city of Philadelphia. I am a United Methodist minister by vocation, and a Congressman by accident. My background is that of a street minister. I have been in Congress for 9 years and was one of the persons who worked very hard to establish the readjustment counseling centers.

My experience in the past is that there is a population of people, both on the outside and within the veterans community, particularly Vietnam vets, who cannot find their way psychologically into the antiseptically clean facilities of a hospital setting, and that with the establishment of the 135 outreach centers that we have in place, and I support your effort to increase the number of those outreach centers, what I think the VA has learned, backed off from some of its opposition, is that yes this is a way to get those veterans, those that are unemployed, those that are having medical problems, those having family problems—you talk about wives and children—to actually come to a place where a peer, one-on-one setting or in group settings they can begin to address and relate to some of their problems.

It may not clearly be defined with definition of a term. We call it posttraumatic stress disorder. That is a large umbrella under which, as you I think rightly state, are a number of issues. I think with the experience that VA people who objected to these centers, they are now coming back and saying, "Yes, we like the centers, we want to see them expanded, we think we can work with them better, and we have got recommendations for improvement." So I appreciate your point there.

On the pilot stress ward, this committee did visit one of the eight facilities across the country that specifically deal with the issue of posttraumatic stress disorder. Congressman Lane Evans and I particularly had a chance to sit down and rap with those who were in in-service in patient ward settings in Chicago. It was very helpful for us to see them.

On the incarcerated veterans, in my previous life I was also a chaplain at a Federal penitentiary in Lewisburg, Pa. I found not only many veterans who were in that facility, but people who came to that facility with psychological and emotional problems that were not dealt with very adequately. I think the VA does have a responsibility there.

I would like to in closing talk about the Daschle bill for a moment, H.R. 1961. A milestone was crossed in that the subcommittee that deals with compensation of our House Veterans' Affairs Committee unfortunately voting down party lines did pass that bill prior to our adjournment last Thursday. In early September all of us on this panel will have a chance in full committee to vote on the Daschle bill. It identifies liver disorders and soft tissue sarcomas as the three compensationable diseases that we presume causality between the use of the defoliant and the systemic diseases in three categories.

I think you are right in underscoring that agent orange up to this point has been a political problem; that the politics of it relate to finances, they relate to pressure of OMB, pressure of the administration. It is not a Democratic or Republican problem. It is a problem of responsibility.

Those of us on the committee who believe that presumption of causality should be determined have been working very hard, and we think that the Daschle bill is a first step, toe-in-the-water-type of opportunity.

We learned some interesting things, that there are certain diseases—diabetes and other diseases—where presumption of service connection is made. We think that there are some presumptions in the area of agent orange that ought to be pursued. It is a tough question for some Members of the House and Senate. I think we have a chance at the Daschle bill. I would hope that the Vietnam era community would get behind that, even though in a more optimistic time, a time when we have a little more opportunity, we would like to see an expansion of that legislation.

Excuse me for my sermonizing, but I wanted to go through the points you made which I thought were very good.

I yield to Ms. Kaptur.

Ms. KAPTUR. Thank you.

Mr. Camacho, I have no questions. I am a new member of this committee. I considered your testimony to be extremely powerful. I shall never forget it. I think that the people of this State, certainly the Vietnam vets, are fortunate to have you working on their behalf. I think you have made an outstanding contribution here this morning.

I look forward to working on this committee. The reason I asked for this committee when I was elected last year was because I felt a special responsibility to all veterans, including those of my own generation. I appreciate your coming here this morning. I also want to mention the Job Training Partnership Act, because I come from a region of the country where there is very high unemployment. I was instrumental in trying to get our Vietnam vets to work with the JTP. They did not even know about it.

I don't know all the things you are doing. But you are right on target.

Mr. CAMACHO. It is an extremely tough situation in this State. I would imagine if it is tough in this State it is tough across the country. We are being endangered of being cut out of title II. Nobody knows what is happening with title IV.

Ms. KAPTUR. In full committee, Mr. Chairman, we encouraged Chairman Montgomery to notify the Governors about the Job Training Partnership Act and the linkage between veterans and the structures being set up across the country. Hopefully that was done. But there is nothing better than people becoming involved at their own level here.

Mr. CAMACHO. That is the point. We are trying to build the public space for Vietnam vets.

Ms. KAPTUR. Thank you.

Mr. EDGAR. Congressman Evans?

Mr. EVANS. I also thank you for your superlative testimony. I wish we would have had it when we were considering the post-traumatic-stress disorder bill.

Mindful of your desire not to build a dichotomy between vets of the Vietnam era and other wars and eras, isn't there really part of the underlying problem, dealing with post-traumatic-stress disorder, is an attitude problem among older people in the VA who really felt in regard to veterans of World War I or perhaps Korea, those veterans were taken care of and they don't understand how it could be that Vietnam vets are not being taken care of.

Mr. CAMACHO. That is why I stress the notion of guerrilla war. It is not the viciousness of jungle combat, which is similar to World War II in the island campaigns, or the Hue City kind of scenes, which is similar to European things. It is the fact that it is guerrilla war. I don't think the older generation of veterans really can conceptualize that. It is not a matter of a few civilians getting mixed up. It is a matter of civilians being the guerrilla. When you have that problem, it is a whole different ball game about how do you fight that war. It is not necessarily always a military search and destroy answer, which creates more problems than it solves in some cases.

Mr. EVANS. Coupled with the homecoming problems where the jobs were not available as they were in World War II, the GI bill wasn't what it was.

Mr. CAMACHO. We pointed it out in the Commission. The return, the ethnic, the European ethnic of the Depression, returning from World War II, an expanding economy, wide open reception, organizes quickly, pursues the avenues of social mobility, and attains access to the middle class. The new veterans, minority veterans, Hispanics, Cubans, Mexicans, Portuguese, Puerto Ricans, poor white working class, come back, there is a negative reception, a slump in the economy, the stigma prevents you from getting jobs.

Then another little slump in the mid-1970's. Now, we have no employment experience. So who is going to hire you. You have been unemployed for 10, 12 years, or you have only had so many jobs. A different situation.

Mr. EVANS. Talking a little bit about policy argument in the sense we cannot give agent orange compensation because it is the tip of the iceberg. That has been focused onto a great degree. I wonder if you could make a comment. What about our sons and nephews, what kind of policy? In terms of policy, how are we going to get other people to serve in the future if we look at the Vietnam vets.

Mr. **Camacho**. I will tell you. It is not even my opinion at this point. What we heard from over 50 percent of all the Vietnam vets we talked to in the public hearing sector or stage or our Commission, 8 hearings, at least 60 people at each hearing, that is 30 people per hearing. "My son isn't going anywhere—if you treated us like this, you expect me to send my son down there?" "Down there" was reference as to the Mideast, references to El Salvador in particular, jungle warfare.

The dioxin issue of our children—that is broader than a Vietnam veteran issue. It has to do with pollution. Taunton, Acton, Woburn, now Norwood. They all have water problems, pollution problems. Where do you dump this stuff? Dioxin opens a Pandora's box, the biggest issue in my estimation by 1992 which will be chemical waste and water. That is already a problem here. Already the western part of Massachusetts is complaining about Boston trying to do some finagling with the Quabin Reservoir. Very important here.

Mr. **Edgar**. I just want to argue my colleague should support my National Ground Water Commission which will be up in the Research Recovery Act when we get back, which does an overall view of water needs.

Mr. **Camacho**. If it doesn't sound too oddball, I would say there is only one way to get rid of this. We said in the 1950's you would say you never would have a guy on the Moon. Put into space. Throw the money into NASA, and just get rid of this stuff. Every State have a space shuttle. Just get the stuff out. You cannot bury it in the ocean or in the ground. It has to go somewhere. It might as well go to the Sun.

Mr. **Edgar**. You would have to send all of Illinois there I think.

Mr. **Evans**. One more question. It is not directly related to your testimony. Because of the problems Vietnam vets particularly are facing, I think what they would find after the Daschle bill was passed, does your Commission have any point of view on judicial review of veterans claims. It has been suggested by other Vietnam vets that everyone with the passage of the Daschle bill and other kinds of compensation, let's say for the atomic vets, without the availability of Federal court appeals, it will really mean nothing—with the attitudes of many people in the VA that feel that post-traumatic stress is not really a problem, particularly of Vietnam vets.

I think that problem may prevail with their attitude toward agent orange.

Mr. **Camacho**. Thank you. We support the judicial review thing. The whole idea. The VA has been like an overlord on us. We want that changed. And everyone, if I was of a different opinion, the population of Vietnam vets that we have come in contact with all say similar things. And they want that judicial review out there, absolutely.

Mr. **Edgar**. Thank you. The gentleman from Georgia.

Dr. **Rowland**. I really appreciate you being here. The testimony that you gave helps to point out the differences very clearly between the other wars we have experienced and the Vietnam war—guerrilla warfare, the homecoming that you experienced which has contributed so much to the post-traumatic stress disorder. Although I am not familiar with the storefront facilities that you spoke of, I am certainly supportive of those as I have learned more about it. And then on top of all of this we have the dioxin business, which is coming more and more to the front. I have some questions about that.

When you were testifying I could see the panic in your face about what people are feeling now who have been exposed to dioxin and how will they deal with that, and how will the Congress deal with that. It takes a long period of time to substantiate a causal relationship between dioxin and ionizing radiation and what really takes place. You mentioned some studies or a commission that would need to get going and try to find out what we need to do about this. But this takes a long time. What is your opinion about what should be done insofar as presumptive causality with relationship to dioxin? How do we deal with that right now?

Mr. CAMACHO. When you have 35-year-old guys walking in and they get some kind of wierd inexplicable health problems, and you cannot attribute it that much to alcohol abuse, to drug abuse. How does a 35-year-old guy, 32-year-old guy, suddenly get a liver cancer or this or that kind of cancer? We have a guy, Warren McCrillis, chemotherapy isn't going to do him any good. He is doomed. If it looks like cancer, then presume you might have got sprayed if he can show that he was in an area that got sprayed.

DOD has a huge war room, who got sprayed, when, what units moved in. If it is cancer, you should get that health care right there.

If they want geriatric health care, all right. But they also better go into cancer health care. If I suddenly have cancer tomorrow, I cannot figure out why I got it, except it must come from Vietnam. I am too young. Isn't it an older disease? I am not a doctor, sir. But even more important, the children aspect. I cannot tell you. It is easy to say, you say, "Gee, John's son, something is wrong with the boy. Gee, that is too bad." I don't know if you are married and have children. But I am married and have a 4-year-old and a 1½-year-old. I know any mother or father will agree—when it is your child, it is a whole different ball game. Instant panic. I cannot necessarily attribute it to agent orange. I am not trying to say my son is a victim of agent orange. It can be attributed to a lot of things. But that creates the panic situation. We don't know. We don't know. And we want answers.

You are telling me that the answers take a long time. So I am going to say in the meantime presume if the husband has cancer and the children have some deformities, that you have to make a connection there. If not in compensation, at least in free health care. I don't know how you are going to afford that, of course.

Dr. ROWLAND. One other question. I guess this is a philosophical question. Again I refer to what you said about the difference between the other wars and the war we had in Vietnam, where there was guerrilla warfare. Do you think if we had had an all-out effort in Vietnam, that we could have won that war?

Mr. CAMACHO. I have read a lot of books about Vietnam written by various officers, etc. I am going to tell you right now the thing would have expanded, expanded, expanded. China would have jumped into Korea. You would have had a world war III on your hand, somebody would have had to drop a nuke. The point is you just would have gotten deeper and deeper.

I went to Laos. We jumped into Laos and blew up tons and tons of ammunition dumps. How far into Laos? Up into Southern China? You would have had 10 million Chinamen coming down there. They would have gone into Korea for a second front. I don't think they would have stopped. I don't think it would have stopped.

You asked for a philosophical—you opened the door. I am going to ask this question which I asked Senator Cranston, who came to Boston the other day. What mothers, or fathers for that matter, send their 11, 12, 13, 14-year-old out to mess around in the presence of a professional Army? To mark, to target positions with water buffalo sticks? To deliver messages to IRA people? To throw bottles at British soldiers? To feed messages to Solidarity groups in Poland? To mess around in the presence of yellow rain in Cambodia, or Afghanistan? Or to fight a brutal massacre such as is going down in Central America?

No mother, no father does it. No peasant does this. A peasant doesn't want to fight. A peasant wants to eat. So there are other problems here. Something is fundamentally wrong when a parent says the only break you are going to have is to join the revolution. I am just telling you. That is a fact of life. That is commonsense. And that is my kind of emotional, philosophical bottom line.

When a mother sends her 11-year-old out to play games against a formal Army something is fundamentally wrong. I don't care where you are, what country we are talking about. It has nothing to do with a left-right dichotomy. It has to do with staple issues—food, education, housing—life chances as Max Weber would say..

Dr. ROWLAND. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you for your testimony. I appreciate your coming this morning.

Mr. EDGAR. [illegible] to call the final witnesses in a panel.

STATEMENT[illegible]B PHILLIPS, VIETNAM VETERAN; JAMES BLAKE, [illegible]OM[illegible]ER, DEPARTMENT OF MASSACHUSETTS AMVETS, WIL[illegible]cLEAN, PRESIDENT AND HOSPITAL COMMITTEE CHA[illegible]EW ENGLAND CHAPTER, PARALYZED VETERANS [illegible]A; GARDNER S. McWILLIAMS, COMMANDER, DEPART[illegible] OF MASSACHUSETTS VETERANS OF FOREIGN [illegible]ARS; AND EDWARD PARKS, DIRECTOR, NORTHEAST REGION, AMERICAN EX-PRISONERS OF WAR

Mr. EDGAR. What I would like to suggest, because of the pressure of time, is that we go through each of your statements, asking you to summarize. If a statement has been made before, you might mention it for emphasis. I don't think there is a need for us to go into great detail on issues we have heard discussed today.

The fact that you are here to testify is critical and important. Throughout the country we have asked the veterans service organizations to give us a full accounting of what they perceive as some of the needs for veterans' health care. The question that I asked the regional administrator—one of the tones of our hearing—about what is a 5-year, 10-year, 20-year plan for veteran's health care is a question I hope you will address in writing to us and not be afraid to look innovatively at the veterans' health care system.

I might also point out Mr. Parks is here from the Ex-Prisoners of War. In the midst of our Chicago hearings—we had a limitation on speakers that we could invite to testify—one of the representatives from the Ex-Prisoners of War in the audience very politely stood and raised the comment that they felt slighted they were not invited. Not all the veterans' organizations are able to be invited because there are so many. We do respect all of the views of the veterans' organizations nationally. Hopefully, in the course of our hearings everybody will get at least an opportunity to make their still small voices heard very loudly within the record.

We appreciate Mr. Parks being here representing the Ex-Prisoners of War.

Let's begin with Bob Phillips, a Vietnam veteran. Thank you for coming.

STATEMENT OF BOB PHILLIPS

Mr. PHILLIPS. Thank you.

Members of the Commission, I am Bob Phillips. I am a 36-year-old Vietnam combat veteran from North Cambridge, Mass. I am currently receiving care from a Veterans' Administration facility at Bedford, Mass.

Two years ago, before I sought help, I was working as a district sales manager for a large corporation in this country and success came to me at a very rapid rate. Along with that came a substance abuse problem, which led me to financial disaster as well as personal conflict.

The VA, via the Bedford VA, reached its hand out to me and pulled me into its care. After 18 months of personal examination, treatment at the facility, group and individual therapy, and dealing with issues relative to Vietnam, I have been able to work, to resume work once again in the telecommunications field as a sales manager and now have regained the trust of my friends and family and am paying my creditors.

I can say today my future looks bright, thanks to that treatment at that facility and programs like the Bedford House at the Bedford VA hospital. This program, as well as others, has produced hundreds more successes.

But today, I would like to make you aware of my fear that the hand that reached out for me and others is losing its firmness. Budget cuts have caused hospital administrators to jockey people around and the program we feel is being phased out. In the past year since I have been at the facility, four staff members have been replaced, not terminated, but transfers or job relocations or career changes. Presently, a social worker who has been with the program for 12 years is being transferred and not replaced.

There were only two social workers in our unit, and now the other's duties will be twofold, because he also, besides therapeutic matters, he aids in this problem. Paul has mentioned, and you have mentioned, Mr. Chairman, on legal matters, and he is responsible for interviewing veterans that are in our penal institutions in the Commonwealth of Massachusetts, and also at Attica and other prisons across the country. Who will then now interview those veterans? Who will now go to those penal institutions?

I wish to make you aware I also carry with me some letters from guys that the facility has helped. Richie, Ed, Jesse Segal, on the dean's list at a local university, who were in prison. Ritchie manages two hair salons in the area now; Bob is a welder, a plumber; Jesse a student of culinary arts. He was serving 3 to 5 for armed robbery and was introduced to the program at the Bedford facility. He is now leading a productive life.

Budget cuts are necessary. We all must live with them. My only concern is that we ask as Vietnam vets and other veterans is that when the jockeying and the jiggling of books go on, our administrators in these hospitals or facilities conscientiously examine those problems vital to Vietnam era veterans and other vets. These programs are necessary so that we can live and live a more productive life.

Our country called upon us and we responded at the siege of Keson, Danang, Mekong Delta. We ask you to hear our call, and that is to keep our programs and others intact.

In closing, I would like to answer your question that you posed to the veterans hospital directors here. I just wish that in the 20th century or the 21st century, the year 2000, that the care that I have received remains intact and continues at the level that it has, because it has helped me and many others. But I also hope that the programs available to us increase and remain intact and those staff that are vital to that program.

Thank you very much.

Mr. EDGAR. Thank you.

Did you mean the letters to be made a part of the record?

Mr. PHILLIPS. Yes, I did, sir.

Mr. EDGAR. Without objection, all of the letters will be made part of the record of the hearing.[1]

James Blake, Department of Massachusetts AMVETS. We welcome you here. Thank you for your statement today.

STATEMENT OF JAMES BLAKE

Mr. BLAKE. Thank you, Mr. Chairman. I have a copy of our prepared statement.

Mr. EDGAR. The full text of your statement will be made a part of the record.[2]

Mr. BLAKE. At this time the only additions I would like to make to that statement is the fact that I am a veteran's agent. Sir, I quite frequently bring veterans to the medical facilities in Massachusetts. Court Street, I have patients that think so much of Court Street. They have money available to them to go to other facilities, but they just think that the treatment that they receive there is tremendous. Absolutely tremendous.

On at least five or six cases in the last year I brought veterans to Jamaica Plain. At first they were really hesitant to go to a veterans hospital. In every single case they would rather go back to the veterans hospital than to our local hospital. I would just like to let you know that. I think this is very important, because people today have medical insurance, but when they are about to make the choice of where to go, they pick a veterans hospital instead of a local hospital. To me, that points out that you have to keep this hospital system intact and assist them in any way possible, because they appreciate it, they really do.

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[1] See pp. 118–138.

[2] See p. 139.

I thank you very much.

Mr. **Edgar**. Thank you.

Mr. William McLean.

STATEMENT OF WILLIAM McLEAN

Mr. **McLean**. Thank you, Mr. Chairman, members of the subcommittee, for giving me this opportunity to present PVA's views.

I have very little to say other than the prepared statement, except for an update that occurred in Portland, Oreg. We just came from having our 37th Paralyzed Veterans of America Convention. Mr. Walters addressed us and he spoke and raised one point that I did in the prepared statement—Veterans' Administration games and the athletic abilities of the handicapped people in wheelchairs—it will last them all their lives.

Dr. Custis addressed the geriatric problems of the coming decade, what we could do, or what he could do to address the spinal cord injury care problem. The one point that was brought up new was that we are losing our spinal cord injury chief at West Roxbury. This bodes ill for the medical area and treatment of the spinal cord injury veteran. They have not found as yet a replacement for the RM and his chief. This bodes ill for the rehabilitation of not only the newly acute but the old acute.

Those two, I think, are the most important things that could happen to improve medical care treatment and rehabilitation at West Roxbury, is a new chief of RM&S, and a new chief of the ASCI service.

One other aspect of the geriatric problem. They are stressing that nursing homes be close to or at tertiary care hospitals. The problem lies with our outlander members of spinal cord injuries who perhaps are up in Maine, no SCI center there, and you cannot disrupt the family to send the veteran down here to a nursing home. What happens to his wife and the family? New England PVA is stressing that the VA nursing home be attached to any VA medical center.

Thank you for this opportunity to make those additions, Mr. Chairman.

Mr. **Edgar**. Thank you very much for your complete statement and those additions that you have made.

[The prepared statement of Mr. McLean appears on p. 141.]

Mr. **Edgar**. Mr. Garner McWilliams, commander, Department of Massachusetts Veterans of Foreign Wars.

STATEMENT OF GARDNER S. McWILLIAMS

Mr. **McWilliams**. Mr. Chairman, and members, on behalf of the 62,000-plus members of the Veterans of Foreign Wars in Massachusetts, of which I am the leader, we thank you for bringing this hearing to Boston. And I must say, before I hit a couple of high-light of my testimony, it has been a great education for me today to sit here and listen to the directors of the hospitals, and again the Commission of th Vietnam Veterans.

I was very fortunate to be last week with Senator Alan Cranston, so I am familiar with the testimony. You allowed me a little more time today and Senator Alan Cranston did, but he is interesting to be with, and he gets his point across, and we, at the VFW, are very proud of him.

You have a number of copies of my statement here, but we, in Massachusetts, consider ourselves very lucky to have what we do have in Massachusetts, and they are run as well as they are run according to budget and whatever problems that might come up. We do feel fortunate to have the facilities we do have here.

As you know, we lost a very good friend in Massachusetts, Mr. Chairman, with Hon. Margaret M. Heckler, who has done very, very much for the Massachusetts veteran. She has helped us out quite a bit now. Of course, she has a very important position as Secretary of the Department of Health and Human Services.

The younger vets in the State—fortunately there are outreach programs. We are asking you to maintain what we have, if not increase more of the outreach programs in Massachusetts.

It is our opinion that the health care personnel in our VA facilities are highly competent and, according to their budget, are doing the best they can for us. There are some places here and there that, through our service officer we have assigned to the Department in Massachusetts, gets his normal gripes. But the pats on the back outnumber the gripes.

We would like to be a part of our year 2000 program through our service director—if we could submit through him to you people, perhaps through Congressman Moakley—some type of idea of what we have in view that might help you.

Again, I thank you for the opportunity to be here today.

[The prepared statement of Mr. McWilliams appears on p. 148.]

Mr. EDGAR. Thank you very much.

Mr. Edward Parks, Director, Northeast Region, American Ex-Prisoners of War, Inc.

STATEMENT OF EDWARD PARKS

Mr. PARKS. Yes. I am Ed Parks, a member of the American Ex-Prisoners of War, Inc. I was incarcerated by the Germans in World War II. You have my written comments. I am not going to go over all of these comments.

Briefly, I was only notified about 3 or 4 days ago, so I didn't have adequate time to get a lot of data together to put into my report, but I would like to stress that one of the main problems of the Ex-POW's goes back to when we were liberated basically, repatriated— World War II and Korea—that we didn't receive adequate physicals, both when we were repatriated and also when we were separated. You can see the problem, approximately 20 million veterans, they just wanted to get rid of us.

Also, to compound the problem, the few records that were available, were destroyed in the St. Louis fire. And that is one of the problems that the former prisoners of war have run into through the years with the VA, this lack of medical records. Many of our problems, hospitalization, wounds, diseases, et cetera could be documented only by the Japs or the Germans.

Many times the former prisoner of war would come up before an adjudication board, and they want a statement from the attending physician. Some of those things are ridiculous sometimes.

As you know, in 1981, Public Law 97-37, effective October 1981, was to remedy a lot of the above problems. This law has been slow to be implemented. The intent is there at the higher level and doesn't always get down to the privates. We have been waiting a couple of years for implementation of the law. We have been waiting 35 years to really tell our story. But there are medical administrators supposedly in each facility. We found many of them are not really aware of all the directives that have come down.

Even at this late date, not all the POW files are being flagged. I will comment, though, that there seems to be fewer complaints on the dental service to ex-POW's. That is, people that were 6 months or more incarcerated. So the POW's are getting the dental services.

But aside from my written statement, not being able to document some of these things—document problems of the approximately 88,000 living POW's. Better than 4 out of 10 of those liberated have already passed away. So our death rate is a lot higher than the average veteran.

I think we should have better research on both the physical and psychiatric problems of people being incarcerated. This would have prolonged some lives. If we had had this Public Law 97-37, if it had been implemented, this would have then given the ex-POW access to VA facilities, and I feel that many of these men would have lived a longer life, and many of them could have been alive today.

I want to commend Mr. Camacho on his presentation of the outreach program as related to stress and so forth. This is something also very unique to the ex-POW. Don't forget, every POW was either on a plane shot down, ship that was sunk, foxhole overrun. And whether you want to call it post-traumatic stress, delayed stress syndrome, it also was related to POW's, KC syndrome, or whatever you want to call it, they can have it.

Paul talked about the homecoming. The ex-POW's, many of them I know, had a real stress problem when the 52 hostages came back. As I said we were just brought back—100,000 just released. This hostage release and publicity triggered many problems for the POW's. They could not understand. We had never been recognized—our suffering. When we compared what we went through to what they went through—not that I wouldn't say if you lose one hour of your freedom, that this is not important. The 52 hostages did go through something. All you have to do is talk to any woman or anyone who is held hostage 2 or 3 hours in a bank, the stress that they go through. We did go through that same stress.

I'll just give you one case. There was an ex-POW from the Korean war. This hostage thing triggered him off. He should have had psychiatric help. He went in his garage, started his lawnmower and sat on it. Just caught him in time and he was saved. He just went in the garage, closed the doors, started the lawnmower and sat on it.

The problems of the Vietnam veterans, the need is for outreach. We have the same problem with the ex-POW's. I don't think the VA has located over half of them. I know they approached the other major veterans groups to turn in the names of the ex-POW's, as they may know who they are. The VA was supposed to notify all the POW's, tell them what their benefits are under Public Law 97-36. Quite a high percentage have never been notified of the law and their benefits.

I would like to give you just a short example. My wife had my car with ex-POW plates on it. She was in a building just 2 days ago. This woman came in. She said, "I am married for the second time. My husband is an ex-POW from the Korean war. He is pretty sick, confined most of the time at home with cancer."

My wife mentioned our ex-POW group. She had never heard about it. She said, "When he came home," she said, "he just went in like a beehive. He has never joined one veterans group, never associated with veterans, never been to the VA, wants nothing to do with the Government, just glad to be home."

I am going to investigate this man next week. I bet he is one of the 40,000 the VA doesn't know exist.

The POW's also have this unique problem, they crawl into their shells and they need help. Four out of ten that were repatriated have already passed away. Of course, we have to talk a lot to make our voices known, because we are only 0.3 percent of the veteran population, and you want to know really what is going to happen.

I might say we are in favor of judicial review, because if we had had that before Public Law 97-37, perhaps a lot of our men would have been able to get some aid due to this judicial review process.

You want to know about the program for the year 2000. We will think about it and maybe respond. But we don't think we will be here by then.

Mr. **Edgar**. Some of you will. Remember, there were prisoners of war in Vietnam.

Mr. **Parks**. Unfortunately, there was only 600 or so came back. Hopefully we may get some more back. They have all been identified.

[The prepared statement of Mr. Parks appears on p. 151.]

Mr. **Edgar**. I guess I have to take a little bit of issue that there is one prisoner of war—someone once said that in war there are no unwounded soldiers. Maybe all of us are in a sense prisoners of war when we think about the fact that war is about 30 minutes away by air at any given time in our history.

I think Mr. Phillips is a good illustration of someone who came back from a war setting and went back into productive life, and tripped and stumbled. Fortunately, there were resources in place to help bring him to his feet again and help him along the way. I think for prisoners of war, for World War I, World War II, Korea, and Vietnam, veterans who were exposed to toxic substances as well as lethal substances, bullets and other implements of war, the VA has been put in place to try to respond in a loving, caring way. If one veteran gets helped and able to be lifted up in the process, I think it is an important event.

And if by the year 2000 we can have a health care and veterans program in place to meet the needs without breaking the back of the Federal Government, I think we will be doing ourselves a great service.

You have been kind to come and present your testimony.

Are there questions from my colleagues?

Ms. **Kaptur**. I have no questions, in the interest of time. I did want to thank all the panelists for waiting such a very long time. We have your full testimony.

As the chairman said, if you have any additional comments you would like to submit to us, we will welcome them.

Thank you very much.

Mr. **Edgar**. Lane Evans.

Mr. **Evans**. Mr. Blake, your statement No. 1, on the experiments. Do you have any instances of that? Can you document those?

Mr. **Blake**. When we got your letter of this commission, we had a meeting with several of our past commanders and also some of our VAVS people. I do have—I cannot document it myself, but it can be documented from one of our past commanders. They had a problem. They were very concerned about that.

Mr. **Evans**. We are very concerned about people being experimented with without giving adequate consent.

Mr. **Edgar**. If you could give us some more information for the record on the specifics, it would be very helpful.

Mr. **Blake**. I would be happy to include that in a letter to you.[1]

Dr. **Rowland**. I have no questions.

Mr. **Edgar**. Let me just ask one question, and then we will close the hearing.

Does the State of Massachusetts participate in the State Veterans Home program? It is for nursing home facilities, hospitals, or domiciliary care facilities.

Mr. **McWilliams**. I would say we do, sir.

Mr. **Edgar**. Do you have a State veterans home?

Mr. **Parks**. Chelsea Veterans Home, and Holyoke.

Mr. **Edgar**. They provide nursing home facilities and domiciliary care facilities?

Mr. **McWilliams**. Yes. We have a number of halfway houses, they call them.

Mr. **Edgar**. Are there any hospital beds provided in either of those two facilities—are they nursing homes, halfway, and domiciliary?

Mr. **McWilliams**. At Chelsea.

Mr. **Edgar**. You might be interested to know there is a bill which we passed in our committee and through the full House, pending in the Senate—and we are dickering with the Senate on numbers in terms of an increase in per diem for those State homes. We are very supportive on this committee of encouraging States to look at the possibility of expanding the State Veterans Home program. Because of the limited resources at the Federal level, we believe that a partnership ought to be developed between State and Federal Government.

As you know, the per diem costs of nursing home care was originally about 30 percent Federal and 70 percent State responsibility. The Federal percentage has slipped because of inflation. The bill which we passed would bring it up to still about a 30-percent commitment.

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[1] Not received at time of publication.

In the area of construction for the State homes, the Federal Government will permit up to 65 percent of the construction of the facility. States will then have to come up with 35 percent. And we have renovated and reconstructed some facilities. There are some old sailors and soldiers homes in military facilities that have now been taken over in the State Home program that have been upgraded substantially and improved the quality and ability for the State facilities to be cared for.

It is my feeling that one of the innovations that is going to have to take place as we move on is, in order to meet all of the needs, not only will the veterans health care system have to be adequately funded, but more State-Federal partnerships are going to have to be developed. So I encourage you, as State commanders and others, to visit your homes, as I know you do, to encourage the development of those facilities with your Governors and State legislatures, and to encourage us at the Federal level to keep our commitment, both in terms of per diem and for cost of construction of those facilities.

Thank you very much.

Mr. BLAKE. Mr. Chairman, I have one question and comment to make to you. In regards to private nursing homes, it seems that it is harder all the time to get a veteran into them because of the fact that they are trying to upgrade their facilities, and the money that they can get from private patients is higher than the average veteran can afford or the veterans system that this person is living under. And this seems to be a big problem. So the partnership is not going to come easy. It is very difficult.

Mr. EDGAR. I appreciate that. Particularly in the private sector, that is true. We are going to have to take a look at that very tough issue.

We have one hand in the audience.

Mr. SCHEURHOLZ. Mr. Chairman, the outpatient clinic is the clinic of jurisdiction for the State Veterans Home. They do have 166 hospital beds. The per diem rate is $13.25. They have 68 nursing homes, home beds. Per diem rate is $12.10. This is the present rate. On the domiciliary, they have 305, and the per diem is $6.35.

Mr. EDGAR. Well, I invite you to take a look at the legislation we passed in the House, which is supported by the State Home Association, which would increase those per diem rates and bring the Federal share up to a more reasonable amount.

Thank you very much for your testimony.

I want to thank the staff of the House Veterans' Affairs Committee, and the staff of the Veterans' Administration, and all of those who have taken time to make sure that the facilities and the arrangements for this particular hearing have been accomplished.

The full transcript of the hearing will be published. We will make sure that people get copies of that. We do look forward to our field visit this afternoon.

Again, I apologize to the Members of Congress. You will be interested to know rather than going to a nice restaurant in Boston to savor some of the quality food you have, we gave that hour up in order to hear your testimony. We are going to get box lunches at our first stop. We are making just a little bit of a sacrifice. We know how much of a sacrifice you have made. Thank you for your time.

The hearing is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF HON. BOB EDGAR, CHAIRMAN, SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

The Subcommittee on Hospitals and Health Care will come to order. On behalf of the subcommittee, I wish to welcome each of you to this oversight hearing on the VA's health care delivery facilities in the VA's Northeastern region as represented in the metropolitan Boston and surrounding areas. This is the third of six such oversight hearings the subcommittee plans to conduct during the first session of the 98th Congress. In each of these oversight hearings, we will hear form the director of the VA medical region, witnesses will include private citizens, State Officials and the State commanders of the Congressionally chartered veterans' service organizations.

Following the hearing, we will tour an indedpendent outpatient clinic and a satellite Alcohol, drug and mental rehabilitation center.

The mayor of Boston, the Hon Kevin White, and Governor Dukakis, as well as the entire Massachusetts congressional delegation, were invited to participate in the hearing today, and I'm delighted Congressman Joe Moakley was able to be here. Congressmen Barney Frank and ED Markey were not able to be present, but have submitted statements for the hearing record.

I would now like to introduce the members of the subcommittee present this morning.

This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services to eligible veterans. In the 10 VA medical facilities in medical district 1, there has beeen allocated in the current fiscal year almost $364 million and 9,658 employees to provide health care to eligible veterans, medical District 1 served 51,662 veterans in fiscal year 1982. By 1990, it is estimated that this figure will decrease to 47,920. Outpatient visits in fiscal year 1982 totaled 976,820. By 1990, it is estimated that outpatient vists will increase to 1,225,300. The number of veterans 65 years of age or older in 1980 was 128,180, and will increase by 150 percent to 319,780 in 1990. Nationwide, the VA has estimated that demands placed on the medical system due to increasing number of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over 65 will be veterans. Right now, due to significant unemployment, more and more veterans are coming to the VA for the first time. These facts indicate that we not only have a persent problem but a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illnesses in the older veteran. We must cope with the present demand. But more importantly, we must be prepared to accommodate the future demand on the system as well.

We must also be alert to respond to the unique and changing needs of many other segments of the Veteran population. For instance, we must address the continuing serious readjustment problems faced by thousands of Vietnam era veterans. Yet another example is meeting the medical needs of those veterans deeply concerned about the effects of exposure to the defoliant, agent orange. Likewise, we must provide medical assistance to those concerned veterans who were exposted to nuclear radiation during atmospheric atomic testing, additionally, the Veterans' Administration medical system must remain compassionate and flexible in delivery of health care to all eligible veterans.

The House Committee on Veterans' Affairs is, in my view, the most bi-partisan committee in the United States Congress. Having said this, however, I do not believe that veterans' organizations and individual veterans can sit back and do noting. The VA's health care and other benefit programs have been enacted by the

Congress as the will of a grateful Nation for the sacrifices these veterans made in serving the Armed, Forces of the Nation. But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities. The VA medical budget for fiscal year 1984 is approximately $8.1 billion. However, that figure represents only 2.5 percent of all national health care expenditures. At the same time, the VA has provided part of the training, through its affiliations with the private medical community, for more than one-half of all health care professionals in the United States. VA researchers have alerady received two noble prizes in medicine. The medical research program has been reponsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthoughs in kidnedy transplants, cancer research, renal disease, hypertension and psyschiatry to name only a few. This year medical district one medical centers have been allocated over $7.9 milion for VA-funded research. The VA is the Nation's largest health care provider with 127 strategically located hospitals and 226 outpatient clinics serving as the primary backup to the Department of Defense medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

Another reason for these six field hearings is to learn, first hand, of the present condition of construction, maintenance and repair of VA medical facilities, upon completion of the six field hearings, we will have some ideas on which to build a solid base to provide quality health care to eligible veterans in modern health care facilities. In this regard, there are several construction projects in the pipeline that will affect Massachusetts medical facilities. These are:

(1) $5 million for fire and safety improvement at Boston in 1985

(2) $18 million for design for replacement or modernization of the outpatient clinic and education addition at Boston in 1986; and

(3) $162 million for replacement or modernization of these facilities in Boston in 1987;

(4) $24 million modernization of buildings 2 and 7 at Brockton in 1984;

(5) $11.7 million for clinical improvements and renovation of buildings 5 and 8 at Brockton in 1985;

(6) $33 million for correction of seismic deficiencies at Brockton in 1987;

(7) $54 million for patient privacy renovations and correction of seismic deficiencies at Northhampton in 1988;

(8) $50.5 million for an outpatient addition and other improvements at West Roxbury in 1985;

(9) $25 million for renovation of buildings 4, 6, 7, 61 and 62 at Bedford in 1987; and,

(10) $18 million for construction of a 180-bed domiciliary at Bedford in 1988.

Additionally, the Congress, responding to disastrous unemployment rates across the country, approved the emergency jobs appropriations bill, H.R. 1718. The legislation earmarked $4.6 billion to stimulate employment throughout the United States. I offered an amendment to the legislation, now Public Law 98-8, which targeted and restored over $1 billion to be used for public works jobs and which targeted this assistance specifically for areas of high unemployment. The so-called Edgar amendment was designed to provide additional employment opportunities particularly in the distressed industrial areas of the Northeast and the Midwest. Of these funds, this medical district will receive $3.2 million for 21 maintenance and repair projects in fiscal year 1983.

Again, I would like to thank all of the members and witnesses participating in this hearing, and the VA employees who have provided invaluable assistance in making the hearing possible.

STATEMENT OF
J. T. KRAJECK
REGIONAL DIRECTOR
NORTHEASTERN REGION
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

August 9, 1983

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear before you today and have the opportunity to discuss the Veterans Administration, Department of Medicine and Surgery's provision of health services to eligible veterans in Maine, New Hampshire, Vermont, Massachusetts and Rhode Island.

Department of Medicine and Surgery health services are provided to eligible veterans in the five New England States through a Medical District consortium known as Medical District 1, which is composed of the Boston Outpatient Clinic and eight medical centers: Bedford, MA; Boston, MA; Brockton/West Roxbury, MA; Manchester, NH; Northampton, MA; Providence, RI; Togus, ME; and White River Junction, VT. A map of Medical District 1's primary service area is attached. This area comprises a total veteran population of 1,202,000. My remarks will be confined to Medical District 1.

To address the medical needs of the veteran population, the District medical centers are organized as follows: the Boston Medical Center is the tertiary hospital and provides sophisticated care and treatment to all of the District facilities such as neurosurgery, eye surgery, CT scanning and radiation therapy. The West Roxbury facility performs all of the District's open heart surgery and provides specialized spinal cord injury services and care. Brockton, Bedford and Northampton provide tertiary psychiatric treatment and care. The Medical District is authorized 4,308 hospital beds and 522 nursing home care beds. At the end of June 1983, the number of inpatients treated was 1.9% over a planned workload of 39,709 and the number of outpatient visits was 4.7% over a planned workload of 722,505. Occupancy rates were averaging 84.8%.

The recurring FY 1983 medical care budget for Medical District 1 is $305 million. In addition, the nine VA facilities have a planned Research budget of $9.5 million. These Research programs include medical, rehabilitation, Agent Orange and health services research projects.

The Medical District maintains a very active and positive relationship with its five affiliated medical schools, which assist in providing quality health care to veterans. The medical school affiliations are with the Boston University School of Medicine, the Tufts University School of Medicine, the Harvard Medical School, the Brown University Program in Medicine, and the Dartmouth Medical School. These affiliates provided 361 house staff officers during Academic Year 1982-83.

Legislation has expanded medical care eligibility and added increased dimensions to our workload during the last five years, e.g., Agent Orange and ionizing radiation screening and treatment programs. For the first seven months of this fiscal year District facilities completed a total of 878 examinations for Agent Orange and 24 examinations for ionizing radiation exposure. For the same time period services have been provided for 301 former prisoners of war. While the present level of services is anticpated to continue for former prisoners of war, it is difficult to predict the future workload for veterans exposed to Agent Orange and ionizing radiation.

Services for female veterans represent about 2.7% of the current Medical District workload. Present planning indicates that the demand for medical care services for female veterans will rise during the next five years. All of the medical centers, in anticipation of this increased demand, are including additional facilities in all patient care renovation projects for providing female veterans with care.

The Medical District Initiated Planning Process (MEDIPP) population estimates show a five percent decrease in veteran population, from 1,219,560 in 1980 to 1,164,190 in 1990, but a 150% increase in the 65-years or older veteran category, from 128,180 in 1980 to 319,780 in 1990. These estimates clearly indicate that District planning must address the problems of aging veterans. This means converting acute care beds to extended care or nursing home care beds, redefining missions, improving ambulatory care and outpatient facilities at some centers, and initiating or improving services to elderly veterans. To partially address this issue present, plans are to convert 50 psychiatric beds to Nursing Home Care Beds at the Northampton VAMC in FY 1986 and to identify other facilities for similar conversions.

Many of our medical centers have instituted new programs to better serve our veterans. For example, the Manchester VAMC opened a new 20-bed Psychiatric Unit to offset legal barriers to patient commitments across State lines. The Providence VAMC has opened a new 30-bed Alcohol Treatment Unit. The Boston VAMC has also been approved and funded for a new Stroke Unit and a Comprehensive Rehabilitation Center that will focus current medical practices in caring for veterans with debilitating disorders. These new programs will enhance these medical centers' capability for providing care and treatment and will be accessible to other veterans in the District who are in need.

The medical centers in Medical District 1 range in age from 30 to 59 years and require a great deal of maintenance and repair to keep them in good operating condition. At present, there are more than $67.0 million in construction projects being considered in the planning process in this District to improve patient care and support services, correct fire and safety deficiencies, improve physical plant, provide patient privacy, and maintenance and repair. Included in this amount is more than $3.0 million provided by the recently enacted Jobs Bill. The Fiscal Year 1984 planned allocation for maintenance and repair is $4.8 million and the Minor and Minor Miscellaneous Construction Programs for FY 1984 are funded at $15.4 million.

The Medical District's Construction Plan for FY 1984-89 includes several building modernization projects at Brockton and new clinical additions at West Roxbury, Boston, Providence and Togus. It also includes projects to remove existing deficiencies related to patient privacy, fire and safety, electrical, environmental, direct patient care and support, and seismic improvements. If the Agency were to approve all of the construction projects being considered in the planning process, the total Fiscal Year 1984-89 cost in this District would be in excess of $515 million.

I am happy to report that our ability to recruit some health care professionals has improved. Flexible scheduling for nurses including the use of the ten hour day and use of special salary rates as authorized by PL 96-330 have been very beneficial. There is still a problem in recruiting licensed practical nurses, physical therapists, certified respiratory therapists and some specialty nurses for Spinal Cord Injury and Intensive Care Units. In some instances, it is difficult to recruit for these positions when the private sector is offering free medical and dental insurance and tuition-paid educational incentives.

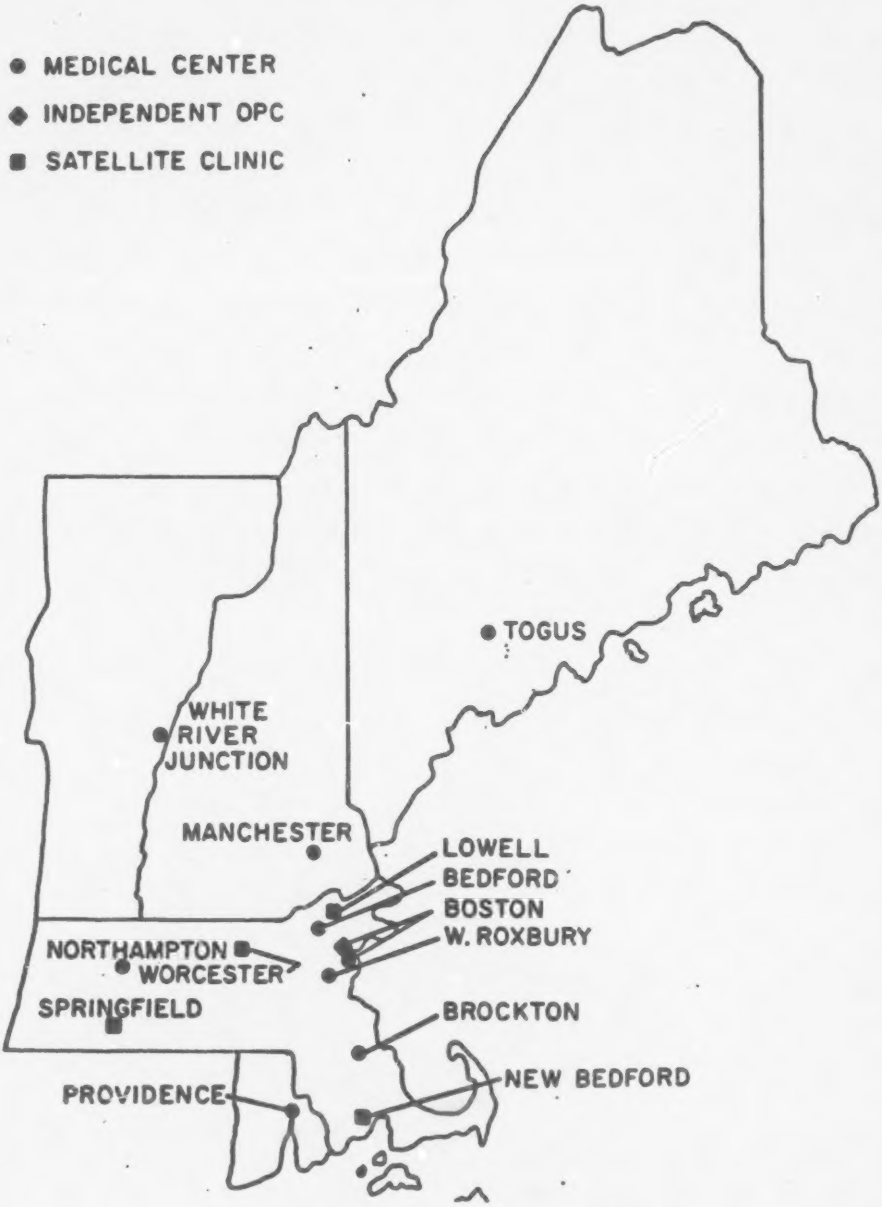
There has been considerable progress in making the District more effective and efficient in managing its resources, particularly in the areas of ADP and laundry services. With the decentralization of ADP, facilities are preparing sites for the installation of computers in Fiscal Year 1984 which will steamline the medical administration and pharmacy functions and permit the formation of a data base to make management information more effective in allocating resources.

We are also developing plans to improve the delivery of laundry services in Medical District 1. Currently, the Brockton facility performs all of the laundry for the Boston and Providence Medical Centers. By Fiscal Year 1988, present planning is to construct a central laundry facility which would perform all of the laundry services for Brockton, West Roxbury, Boston, Bedford, Providence and Manchester Medical Centers. The Northampton facility would consolidate with White River Junction and process the total laundry requirements for both medical centers. The Togus Medical Center would maintain its own laundry due to its distance from other District facilities. If we can accomplish this, a more effective and efficient utilization of resources will result. Also, during this year two Medical Centers, Brockton and West Roxbury were successfully consolidated under one management team. The resources liberated as a result of the consolidation will be reallocated at the facility level to enhance existing programs and staffing.

Wherever appropriate, facilities have sharing agreements with the community and other Federal agencies. The West Roxbury facility has a Medicare arrangement to provide spinal cord injury care and treatment for non-veterans. The Bedford VAMC provides general clinical laboratory testing and laundry services fr Hanscom Air Force Base. The Boston VAMC provides specialized diagnostic tests through formal sharing agreements to several Boston area hospitals and has a formal interagency agreement with the National Library of Medicine. The new law, PL 97-174, allows the VA to explore sharing possiblities and establish sharing agreements with elements of the Department of Defense. Medical District 1 will actively pursue opportunities to enhance our sharing capabilities for providing essential tests and services for all eligible veterans and military personnel.

This concludes my statement, Mr. Chairman. I and my colleagues will be glad to respond to any questions you or members of the Subcommitee may have.

MEDICAL DISTRICT ONE


● MEDICAL CENTER
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WHITE RIVER JUNCTION
MANCHESTER
LOWELL
BEDFORD
BOSTON
W. ROXBURY
NORTHAMPTON
WORCESTER
SPRINGFIELD
BROCKTON
NEW BEDFORD
PROVIDENCE

TESTIMONY OF DR. HOWARD H. GREEN, CHIEF OF STAFF, VETERANS ADMINISTRATION MEDICAL AND REGIONAL OFFICE CENTER, WHITE RIVER JCT., VERMONT

PRESENTED BEFORE THE SUBCOMMITTEE OF HOSPITALS
AND HEALTH CARE OF THE VETERANS AFFAIRS COMMITTEE OF THE U.S.
HOUSE OF REPRESENTATIVES, AUGUST 9, 1983, IN BOSTON, MASSACHUSETTS

Mr. Chairman and Members of the Committee:

I wish to thank you for extending to me the opportunity to testify at this hearing of the Subcommittee on Hospitals and Health Care of the U.S. House of Representatives Veterans Affairs Committee. I will address some of the issues faced by smaller rural hospitals in the system. Even though I will try to deal with small hospitals, I am told that the problems which I enumerate are characteristic of many of the larger hospitals. Underfunding of the system is an issue and I will point out where this underfunding is also preventing optimal care of the veteran. I am acutely aware of the herculean efforts made by this committee to improve medical care for veterans and as a physician charged with oversight of that care in the White River Jct., VAM&ROC I am appreciative. I also recognize that in the regulatory function the Administrator is given broad discretion.

It is generally accepted medical practice to provide long term continuity of care to patients in need of this care. Examples of this are patients with hypertension, arthritis, cancer, heart disease, and diabetes, chronic mental illness, and many other conditions. Many of these patients go through life without frequent hospitalization. It is further accepted that patients should be treated in the least expensive and least dangerous environment to accomplish that continuity. It is the ambulatory care environment which represents the most desirable site for this purpose, with hospitalization reserved only for events requiring this setting for diagnostic or therapeutic intervention. There is an inherent risk to hospitalization which is best to avoid except where necessary. I am aware that it is rare for any veteran in true need of hospitalization to be refused this hospitalization because of restrictions of law or budget. I am acutely aware, however, that once hospitalized the full range of services one associates with private sector large community and tertiary care hospitals are not readily available to our veterans because of restricted resources. As a specific example of this, many NSC veterans have to wait inordinate lengths of time to receive coronary bypass surgery because of inadequate system capacity and lack of funds to purchase these services from the private sector. At the White River Junction Hospital we have not been able to meet the demand for services within allocated budget. In the management dilemma presented, the decision to provide one service of necessity diminishes another.

It is in the arena of ambulatory care where restrictions in medical practice are created for those veterans who do not enjoy the special eligibility created in Title 38, Chapter 17, Subchapter II, Section 610. Section 612 limits outpatient treatment to twelve months following discharge except where the Administrator finds a longer period is required. (Medical rationale can justify this for most of the chronic conditions mentioned above.) This same section provides also for such care to obviate the need for hospitalization. This category is limited in M-1, Pt. I, Chapter 17.31, to four visits. At our hospital we have been forced to move toward a strict interpretation of the law and regulations in order to stay within our allocated budget. The non-service connected veteran is increasingly precluded from receiving continuous follow-up for chronic conditions. Physicians are forced into hospitalizing patients to create eligibility for the follow-up care (even though this practice is precluded by regulation). Our Associate Chief of Staff for Ambulatory Care, Dr. John Wasson, has recently completed a study under the auspices of the VA HSR&D Program which compares veterans who receive continuity of care vs. those who do not. The cost of care for those veterans receiving discontinuous care is considerably greater because of an increased frequency of hospitalization in this group.

The rules force us to inappropriately hospitalize patients to create eligibility for prosthetic appliances or to obtain dental care required for maintenance of good health. In short, the rules create a morass of detail which precludes easily taking care of the NSC population in a rational way. In our case, if we tell a NSC veteran that we cannot follow him then, in view of the financial circumstances of most of our clients, this means no care or follow-up until the next acute episode, since there are no city or county hospitals in Vermont or New Hampshire.

Small stations have some unique problems worth mentioning. These hospitals have all of the functions of large hospitals and frequently on both the administrative and professional side have one person trained in a specific function versus the several who perform that function in the larger hospital. Despite this, small hospitals in this District usually perform their services more efficiently than the larger ones. In most subspecialties in our hospital, one physician represents this discipline. All of these are full time. We do not have sufficient budget to hire additional fractions. One physician cannot give 24-hour coverage seven days per week. If we did have sufficient budget to cover adding additional staff on a part-time basis, we are placed at a serious disadvantage because the part-time physician is not paid on a pro rata basis when compared to the full time physician. In our particular situation this makes such recruitment difficult because the oft reported private sector rewards of part-time status are not true in our environment.

Another area of major concern to us is the shortage of travel/educational funds. The pace of change in medicine and technology has made training and updating mandatory. The sophistication of our work force has increased and in order to stay in the game these people, both professional and nonprofessional, will require increased rather than decreased educational and training episodes. If my recollection serves me correctly, the Veterans Administration ranked 26th out of 28 federal agencies in funds expended per capita for travel and education.

In general, budget restrictions have created a situation within the system where higher paid people are spending time doing work ordinarily supplied by support people - nurses are doing housekeeping duties, physicians do not have adequate secretarial support and therefore cannot carry out their jobs efficiently, nurses substitute as pharmacists on the ward, and ordering of fee basis work has been delayed.

One of the most aggravating aspects of our day-to-day life is the bureaucratic nightmare created in the Civil Service sytem for recruiting technical people. For instance, a position at our station was approved in December 1977 by the Position Management Committee for a microbiologic lab technician. We could not fill it until September 1979. The principal reason for this was that the OPM qualification standards qualify so many people inappropriately for this position that it took one year and nine months to get the mess resolved. This particular situation has a greater impact in smaller hospitals because the position being recruited for is the sole position allocated to the particular specialty or discipline.

Your forbearance is appreciated. Despite what I have said, we are all doing our best to make the system work. My disappointment is that it could be done so much better.

RESEARCH ACTIVITIES OF THE BOSTON OPC/BEDFORD GRECC

Bedford Division GRECC

SENILE DEMENTIA ALZHEIMER'S TYPE (SDAT)

Senile Dementia, Alzheimer Type (SDAT) is a progressive, degenerative neurological disorder of unknown cause and for which there is no effective treatment. The disorder causes a loss of intellectual faculties (dementia) and is the leading cause of dementing illness over age 65. Dementia as a symptom affects 75-85% of patients who require chronic nursing care. In terms of incidence, the total number of SDAT cases in the United States will reach 875,000 by the year 2,000 and at least 200,000 of these cases will be veterans.

Clinically, symptoms of SDAT can appear in the late forties and early fifties but most cases present after age 65. The onset is insidious with early memory loss and episodic confusion but the progressive loss of mental functions (usually without significant motor deficits) results in a total inability to carry out self-care activities at any level and ultimately a need for chronic nursing or hospital care.

Senile Dementia has been a major clinical and research focus of the GRECC at Bedford VAMC since the start of this program seven years ago. A clinical unit of 79 beds, divided into Evaluation, Short/Long Term and Supportive Care areas permits study of evaluation and long-term care methods as well as clinical drug trials. Research laboratories give investigators the facilities needed for basic investigation of etiology and pathophysiology. Staff members have developed clinical criteria which define the stages of the disorder and facilitate early diagnosis. Pilot programs in Respite Care and Family Support Groups are active and have demonstrated alternate care mechanisms which delay or defer chronic hospitalization. In clinical research, a large collaborative study has been developed with other VA hospitals to evaluate the efficacy of lecithin and anticholinesterase drugs in treatment of SDAT. In view of the current "choline hypothesis" of SDAT, such studies have major promise for effective therapy. Other studies, supported by VA Research Service and the National Institutes of Health are being made to investigate the altered molecular mechanisms (neurochemistry), immunological derangements (neuro/immunology - anatomy) ultrastructure and experimental pharmacology in SDAT. These are productive active programs within the GRECC, and they are integral to patient care, staff development, and education.

In summary, the GRECC at Bedford VAMC has a major research and clinical focus in Alzheimer's Disease. This effort has defined diagnostic criteria and developed alternate care modalities for veteran patients. Continuing studies with the goals of understanding the fundamental cause(s) and offering effective treatment of SDAT are being actively pursued.

The Future of the VA Health Care System

Eligibility - Present rules of eligibility, if strictly followed, leads to fragmented medical care which is entirely inconsistent with standards of care in the private sector and contrary to the tenets of good medical practice.

There are many veterans who have been through months of combat, had serious wounds, completely recovered and are now considered non-service connected when seeking medical care.

There are large groups of patients with neurological and medical illnesses that are treated by the VA for their lifetime even though these illnesses have no connection with military service other than temporal. Community hospitals should share with the VA in the care of these patients. Consideration must be given at present to have the elder non-service connected veteran cared for under Medicare.

There should be one standard of eligibility for all veterans.

Community Hospitals - The VA should establish a sharing program with community hospitals and increase its involvement in home health care.

All clinics should be affiliated with acute care VA Medical Centers and there must be a rotation of outpatient and inpatient physician staff.

MEDIPP - It is projected by many experts that health care of the future will be increasingly delivered in ambulatory care settings. These projections, if accurate, will effect the quality of care provided in outpatient clinics. The MEDIPP, (Program and Facility Planning), must be projected into the year 2000 and reviewed and adjusted annually. This program is already off to a fine start.

W. J. Schuerholz
WILSON J. SCHUERHOLZ
Clinic Director

VA Outpatient Clinic GRECC Research

Research in Dementia

Dementia may be defined as a progressive loss of intellectual functions, that may include deterioration of memory, language, and judgement. It is estimated (conservatively) that the prevalence of severe dementia is around 4 or 5% of persons over 65, with another 11 or 12% suffering from mild to moderate losses of function. Many of these patients need institutional care, and many of these patients will die within 5 years of diagnosis. It has been estimated that by the year 2000 there will be almost 8 million veterans over the age of 65, suggesting that dementia will be a challenge of immense proportions to the care providing capacity of the Veterans Administration.

VA Outpatient Clinic GRECC investigators are working to identify dementia subtypes, and determine how these patterns of loss relate to etiology, life adjustment and prognosis. Initial results suggest that some patients may lose basic functions such as language and memory early in the course of the disease, while others retain these basic functions but become so slow and "underactivated" that they cannot take care of even their most basic daily needs. A better understanding of patterns, such as these, and how they relate to the course of the disease, may lead to better treatment, family preparation, and ultimate allocation of care resources.

Psychological Research

Laboratory research on normal age changes of memory and decision making have resulted in improved differential diagnosis of memory failure as well as procedures to improve memory functions in older veterans.

Tests developed to assess the speed and accuracy of cognitive functions of older adults have improved the capacity to specify the defect in memory. Progress is being made to determine the role of depression in contributing to memory dysfunction and new memory techniques are being used on older adults to improve their memory.

Medical Research

Fainting is a common and dangerous phenomenon in elderly individuals which remains unexplained in over 51 per cent of cases, despite expensive, highly technological, medical evaluations.

Investigators at the Boston VA-OPC GRECC observed a disproportionate number of fainting episodes occurring after meals and recently undertook a study to evaluate the effect of feeding on blood pressure regulation in elderly and young individuals.

The results, which were recently published in the New England Journal of Medicine, identify reductions in blood pressure after meals as an important phenomenon in the elderly which may predispose to fainting. This new and previously unrecognized finding may be of major significance in developing treatments to prevent fainting in the elderly.

INCIDENCE OF PATHOLOGY ASSOCIATED WITH RETAINED THIRD MOLAR TEETH

The removal of impacted or unerupted third molar teeth, particularly mandibular molar teeth, is a common surgical procedure, especially in elderly persons who are being given a set of dentures. Seventy-six percent of the members of the American Association of Oral and Maxillofacial Surgeons recently reported the annual removal of more than 2.2 million impacted teeth. This is an average of approximately 1,200 teeth removed annually per oral surgeon. Since dentists other than oral surgeons perform this operation (Odontectomy), the 2.2 million impactions removed by oral surgeons represents only a portion of all impacted teeth removed.

It is of interest to note that if the modest fee of $50 00 per tooth is charged, the cost of the surgery performed by oral surgeons alone is in excess of 100 million dollars. In addition, although most impactions are removed in dental offices, a considerable, but undocumented, number are extracted from hospitalized patients. This adds to the cost of surgery and impacts upon bed utilization. In an era when control of both funds and space is being evaluated, attention has been focused on this operation.

The VA Dental Lontitudinal Study, located at the Veterans Administration Outpatient Clinic, Boston, has conducted a comprehensive study where panoramic and apical x-rays of the jaws were used to provide evidence of the occurence of odontogenic pathosis. This large population provided an occurence profile of third molar teeth that were extracted as well as the incidence of impaction among teeth that were retained.

To quantitate pathology associated with long term impacted third molars, three sets of panoramic and full mouth series radiographs covering a period over ten years in 88 patients (average age 50.2 years), with at least one impacted third molar, were evaluated. They were examined for impacted and erupted (internal control) third molar pericoronal and periapical radiolucency, caries, and periodontal disease; and adjacent second molar morbidity - distal caries and periodontal disease, and root resorption.

The actual maxillary and mandibular impactions associated with a pericoronal lucency were markedly less than the number anticipated. Most importantly, only 20% of these pericoronal lucencies increased in size over 10 years and 96% of the radiolucent lesions were very small. The frequency of new pericoronal and periapical lucencies in impacted third molars, over the ten year period, was only 5.6 and 3.0%, respectively. No significant difference was found between the effects of impacted or erupted third molars on second molar morbidity. This data supports the hypothesis that in an older aged population it may be more efficacious to follow impacted third molars rather than categorically recommend extraction.

EFFICACY STUDIES OF DENTAL RADIOGRAPHIC EXAMINATIONS

Dental radiography provides a significant amount of the information available to the dentist in the evaluation of dentally asymptomatic adults, but much of this information is a duplication of findings which are clinically demonstrable. Radiographic examinations are performed often without first determining their need by history or clinical examination. The two predominant diseases diagnosed and treated by dentists, dental caries and periodontal disease, are generally confined to the coronal aspects of the teeth and the crestal margin of the supporting bone, respectively However, routine dental radiographic examinations often image large portions of the mandible and maxilla not approximating the teeth and, in many cases, other bones of the skull, face and neck.

Although these projections are commonly used in dental practice, there is little evidence to show that, with the exception of caries, dental radiographic examinations which are not indicated by history or clinical examination result in a significant increase in the detection of serious pathological conditions. In the evaluation of caries, there is now some evidence to suggest that clinical examination prior to radiographic examination results in a higher yield than when radiographs are obtained without clinical examination. There is also evidence to show that dental radiographs are often non-diagnostic. In a study of radiographs submitted to an insurance carrier more than half were of such poor quality as to be of little or no diagnostic value. In addition, although the panoramic projection is used frequently in diagnostic evaluation various investigators have shown that this modality is inappropriate for this purpose.

In one recent 12 month period, 59.2 million people (approximately 25 percent of the population) were exposed to x-rays for dental purposes. There were 67.5 million dental radiographic examinations in 1980, increased from 53.6 million in 1974. It had been estimated that there were more than 25,000 panoramic units were in use in the U.S. in 1980, and that approximately 20 percent of all dental machines purchased that year were panoramic.

The U.S. Public Health Service has calculated mean active bone marrow x-ray doses to the U.S. population from the various radiologic examinations using data obtained in a recent survey Although dental radiography gives about the lowest average dose, for any medical purpose, 9.4 MR per examination, 3 percent of the annual per capita bone marrow dose results from dental radiography because of the large number of people exposed

The high costs of radiographic services in dentistry represent a significant portion of total dental expenditures. In an analysis of utilization of dental services in the United States, in 1977, it was shown that, on average, 13.2 percent of all services provided by the 82,000 solo practitioners in the U S. were radiographic, and that they exposed an average of 54 films per week. These data suggest that over 200 million films were exposed during 1977. At an average of $2.50 per film, total expenditures in 1977 for dental radiographic services were $500 million or approximately 5 percent of all dental charges. In 1978 these costs were estimated to be $665 million of the $13.3 billion expended for dental care.

In a study supported by the Veterans Administration and a U.S Public Health Service Grant to Harvard School of Dental Medicine, appropriate criteria for the utilization of dental radiographs are being defined so that patients will no longer be exposed to ionizing radiation as a matter of convenience, in lieu of careful clinical examination and history taking. The use of ionizing radiation in dentistry generates a large expense, much of which may result from self-referral. This VA-NIH study is, therefore, particularly appropriate at a time when concern exists for the proper utilization of health care resources as well as for minimization of radiation dosage. It is identifying aspects of this technology which contribute to over-utilization and will result in a reduction in radiation dose and a decrease of the economic burden to the Veterans Administration and the general population.

Regional Director
Northeastern Region

Pine West, Plaza 3
Albany, NY 12203

Veterans
Administration

September 26, 1983

Honorable Robert Edgar
Chairman, Subcommittee on
 Hospitals and Health Care
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Edgar:

I submit the following thoughts in response to your question regarding what the veterans health care system will look like in twenty years.

Let me begin by reviewing briefly major challenges posed to the Veterans Administration, Department of Medicine and Surgery. First, along with private and not-for-profit health care providers throughout the country, the VA faces dramatically escalating health care costs. We are obliged to recognize that the goal of health care at any price for every individual is unachievable.

Second, additional economic pressures will affect demand for VA services. Adverse economic conditions tend to result in increased Medicare co-payments, diminished employment-related health benefits, and increased unemployment. In the Northeast, the decline of basic industry and the migration of more affluent veterans to the Sun Belt contribute to projections of a largely indigent target veteran population which, although reduced in number, will require enhanced service from our agency.

Third, the public, private and not-for-profit health care sectors share the prospect of delivering services to an aging population. As you know, the elderly require more health care than the young, and the percentage of aged individuals will accelerate more rapidly in the VA target population than in the general population.

I would like to discuss our agency's response to these environmental challenges in terms of the major functions we perform. Regarding patient care, the projected service needs of its aging population place the VA in a position to assume a leadership role in the provision of high-quality long-term care. We want every veteran to function as independently as possible for as long as possible. Since the elderly are often beset with economic and psychosocial as well as medical problems, we must develop a spectrum of services to meet veteran needs. For example, the VA's Geriatrics and Gerontology Advisory Committee has proposed in its 1983 report to Congress the development, expansion and evaluation of the following services:

In Reply Refer To: 10BA1

Geriatric evaluation units (GEUs) prior to longer-term care.
Satellite (cottage) hospital care as provided in the United Kingdom.
Satellite outpatient clinics.
Hospital-based home care.
Respite care.
Hospice care.
Day programs.
Case management and tracking.
Residential (foster) home care.
Education and guidance for families in rendering care.
Nursing homes without walls (NY State pilot program).
Integration of VA medical care activities with community resources.
Innovative programs to meet special needs of institutionalized patients with dementia.

(It should be noted that some of these undertakings may require legislative authority).

Further, the Geriatrics and Gerontology Advisory Committee echoes the Chief Medical Director's mandate that rehabilitation be identified as a high-priority aspect of patient care. With respect to elderly veterans, we must pursue rehabilitation of sight and hearing; rehabilitation of patients with strokes, heart and lung disease, and neurological disorders (e.g. Parkinson's Disease); and rehabilitation of patients with alcoholism and musculo-skeletal disorders (such as osteoarthritis, osteoporosis).

Regarding the VA's responsibility to educate health care professionals, we need to increase training in gerontology and geriatrics. The agency must explore with its affiliated educational institutions the inclusion of geriatric training in all VA-supported educational programs in medicine, dentistry, nursing and allied health. Our agency must take the initiative in strategic planning with medical school affiliates, to ensure that the establishment of housestaff positions is based primarily on the population's health service needs, rather than on medical school faculty expertise.

Turning to another area of potential growth and development with training institutions, we should continue to draw upon the talent of our affiliates to aid us in our long-range planning. As you know, on October 27 and 28, 1983, the VA Geriatric, Research Education and Clinical Center in Boston, and Harvard University's Division of Health Policy Research and Education, will co-sponsor a conference on VA/Community Resources and the Older Veteran. This conference is expected to yield additional insight into the VA's plans for patient care, health services research, the education of health care providers, patients and their families.

With respect to our agency's research responsibility, the VA needs to pursue the channeling of additional resources to research, particularly health services research. Spiralling health care costs coupled with the projected overall increase in demand for services and the need for innovative geriatric care, all suggest that we direct attention to refined techniques of forecasting need, piloting alternative services, and costing and evaluating the delivery of care to veterans. The agency must encourage biomedical and psychosocial research as well, with emphasis on the aging process and diseases associated with aging.

I would like to close this discussion of the VA health care system's future with some thoughts on resource management. With the advent of MEDIPP, the Department of Medicine and Surgery's strategic planning mechanism, we are moving toward resource allocation based on the veteran population's service needs. We will master proficiency in the use of contemporary resource allocation methodologies. Necessary complements to a refined resource allocation process are resources adequate to fulfill the agency's mission, and the thoughtful application of computer technology in managerial decision making.

Those of us engaged in health services delivery, whether public, private or not-for-profit, must pursue cost containment more aggressively. We cannot afford to isolate ourselves as we contemplate the future. The VA must recognize its role, and be recognized, as an integral part of local health care systems. The agency needs to expand the sharing of services, equipment and professional expertise with community health care providers and with the Department of Defense. Lastly, I believe that all health care providers are obligated to address with consumers the painful issue of who will and will not receive services in a world of expanding, costly technology. We cannot deny the reality that even with maximum cost containment, available resources are not and will not be sufficient to meet every individual's health care needs. We must engage in dialog to establish what our choices are and how best to make them.

I am grateful to have had this opportunity to share my thoughts with you. I regard the VA as a great national resource. The agency faces considerable challenges over the next two decades, and I am certain that in our response to those challenges we will amplify our roles in veterans' care, education, research and DOD support.

Sincerely,

J. T. Krajcik
J. T. KRAJECK
Regional Director
Northeast Region

Att.

PLANNING TO MEET THE NEEDS OF THE AGING VETERAN

Rapid growth is expected in the size of veterans 65 years of age and over between now and the year 2000. This is of speical significance to the Department of Medicine and Surgery and the Department's officials who are responsible for Medical District Initiated Program Planning. Such officials are preparing to confront both the increased strain which will be imposed on our nation's largest health care delivery system, as well as the expanding demand for social and economic assistance. MEDIPP is the agency's tool for planning to meet the veteran's health care needs through 1990 in the present cycle. The planning process is designed to involve administrative and clinical personnel at all levels of DM&S. The district plans which result from this process will describe changes necessary in order to meet health care delivery needs in all elements of the Department of Medicine & Surgery.

The greatest challenge to medical district committees responsible for planning is to plan for services to the aging veterans. This is a challenge facing the VA health care system as well as health care nationally. Data suggests that if we continue to provide health care services as we are today to our present share of the veteran population, we will experience a 30% increase in hospital admissions and 17% increase in outpatient workload by 1990.

PLANNING FOR FUTURE TECHNOLOGY

To consider what the future needs of health technology are going to be requires the joint planning effort of technologically oriented clinical administrators and health providers who depend on the technical capabilities of the former for treatment and diagnosis.

To explore the future of health technology needs we must first identify our present technological needs and the status of our ability to meet these needs. In Medical District No. 1 an assessment group of highly skilled clinicians were appointed to serve in an advisory capacity to the District Planning Board and District Executive Council to identify, review and consult ongoing and future technology issues. Their role is to identify specific technology problems and deficiencies and evaluate clinical equipment needs. A major advisory objective is to assess and plan where expensive clinical equipment should be placed within Medical District No. 1 to best serve all veterans requiring the service. This is accomplished within the context of dollars available, mission of the medical centers, and actual need. Within the planning structure of MEDIPP this committee has given us information to develop action plans to request CT scanning equipment within one VA Medical Center and, to obtain CT scanning capabilities for the Medical Center through a cooperative venture with three other community hospitals. Action plans have been further developed to support a proposal for the development of a program in Nuclear Magnetic Resonance at this Medical District's tertiary referral facility.

In reflecting on what the VA approach should be to what future health technology should be we should reflect and learn from our own experience. In 1981, the VA placed approximately eleven CT scanners at tertiary referral medical centers. Since that time clinical application has shown to be appropriate for most levels of care. The approach to CT scanning has expanded from placement of this technology at tertiary centers to providing access to and at some, placement of equipment, at our secondary level of care medical centers. In planning for technology needs into the year 2000 we should be aware that today's specialized tertiary technology may be in fact standard technology for the future.

INNOVATIVE AND CREATIVE APPROACHES

Innovative, creative approaches that may best serve the health care needs of veterans are currently being identified within the MEDIPP process. My knowledge of some approaches include: sharing agreements with the community and the Department of Defense to provide health care for veterans geographically isolated from medical centers; fee basing home health care services in geographically isolated areas; psychiatric nursing home care units. With emphasis on our ability to treat the aging veteran we must develop further approaches to allow us to maintain the veteran in the community, ie., home health services and adult day care programs.

Within present policy of MEDIPP planning we are from the grassroots level putting on our thoughtful creative hat without necessarily being restricted by next year's annual budget. The MEDIPP program as presently constituted provides us with planning tools and arenas for strategic planning to look at what we feel are the real long term needs without fiscal restraints.

SHARING

The Clinical Inventory component of the MEDIPP cycle will be utilized to explore sharing opportunities with the private sector as well as the Department of Defense. As a federal health care agency we should first assist the Department of Defense in improving their capability in meeting their mission which will allow DOD to assist us, especially in remote areas as Aroostook County.

OTHER CONSIDERATIONS

The physical structure of many VA facilities, especially in the New England area, are in need of renovation and/or expansion. While we must plan and develop innovative approaches to maintain aging veterans as well as people in the community, we must also plan for adequate Medical Center facilities to treat those requiring hospitalization. Our planning will be based on patients service needs and demands as documented by demographic and utilization data.

Medical Center

150 South
Huntington Avenue
Boston MA 02130

Veterans
Administration

In Reply Refer To: 523/00

Regional Director (10BA1)
Northeast Region
Veterans Administration
Pine West, Plaza 3
Washington Avenue Ext.
Albany, New York 12205

SUBJ: Congressional Hearings

1. During the Congressional hearings held on August 9, Congressman Edgar asked that we provide him with some thoughts relative to a visionary approach to the Veterans Administration Health Care Delivery System in the year 2000. I shared this invitation with the staff at the Boston VAMC, who found the topic both a challenge and an avenue for expressing concerns and hopes.

2. I was not surprised, nor will you be, to find that their concerns are for broad based, quality patient care. Their hopes are modest and reflect awareness of the political environment, and the inevitable restraint put upon resources.

3. The following are excerpts from the staff communications to me:

A. "With emphasis placed on the care of an aging veteran population, there should be more nursing home care units."

B. "There should be an enlarged gerontology program that includes day care centers for older veterans, especially those who have no family to care for them. The day care center would be so organized that the aging veteran could be socially supported, intellectually stimulated and nutritionally evaluated. This program would be cost effective as it would help to retard the aging process to the point where veterans needed inpatient total bed care."

C. "There should be a day care center for Alzheimer's disease patients. This center could give the same opportunity to the elderly for care that we presently give to young pre-school children of employees."

D. "Develop and promote a continuing education program for health care staff, including ancillary staff, responsible for the well being of patients in specialized fields of enlightened, progressive and holistic hospital procedures."

Regional Director (10BA1)
Northeastern Region

E. "I envision that the Veterans Administration, U.S. Public Health Hospitals, and the military will be consolidated into one medical system for the public. The public would include former military persons, current military persons, and Medicare and Medicaid eligible citizens. These facilities would be strategically located throughout the nation and abroad, and no doubt Boston will be the site of one of these Centers. Near the Center, in the surrounding communities, would be smaller care centers which perform day care and nursing care community services.

The main function of the larger Centers would be to provide an educational opportunity to medical students, and to treat the public defined herein. The persons eligible to be treated would also have the option of seeking treatment at a hospital of their choice, even if it were not one of the Public Health facilities. This would create a competitive environment that should reduce the cost of medical care, provide an individual with a choice, and improve the educational opportunities of medical students.

Though it may not be politically feasible, it is doubtful in the year 2000 within one state such as Massachusetts, that there will be nine medical centers. Perhaps, instead there will be an administrative office such as an insurance building that will pay private sources when eligible persons choose not to be treated at the Public Facilities.

Disability compensation be it social security or veterans administration and an individuals ability to independently provide for himself will be explicitly linked. Our goal then, will be to support the families or individuals during the period that they cannot function independently."

F. "Over the next decade and a half the major changes in the Veterans Administration, Department of Medicine and Surgery, are in the internal management control systems and in the internal management information systems.

In the former, a much more accurate data gathering program will permit cost attribution to each unit clinical function, such as a ward, clinic, laboratory "room" or radiology suite, or diagnostic function, such as an endoscopy suite. Specifically to be included in this planning and measurement system will be the costs of education and research programs, again attributable to individual clinical functions. These, and other "transfer prices" will be included in the total cost of operation of the unit clinical functions.

Concurrently, the development of a clinically oriented MIS will permit both the output from each unit clinical function, and some measures of both clinical process and output evaluation. In other words, for each unit clinical activity, productivity will be established in terms of comparison of clinical "product" to costs. The short and long-term patient outcomes will be included in the evaluation of clinical "product". At the same time, process criteria will be observed.

All of this data will be available to assist in medium-term and long-term planning, such as need for, and efficacy of educational interventions and/or clinical research projects."

G. "All V.A. Medical Centers be updated in accordance with new construction designs, equipped with the latest electronic security devices, constructed with adequate space and office environment features, and be designed and equipped to appropriately treat illness and provide the patient with the most comfortable surroundings."

H. "State-of-the-art computer capabilities, streamlined reporting mechanisms, and up-to-date feedback on all reports which will indicate efficiency and effectiveness of utilized resources...

Appropriate budgeting necessary to purchase or replace diagnostic and therapeutic equipment essential in the treatment of all veterans...

Programs such as GRECC, Female Veterans, Agent Orange, and POWs, receive the highest priority in future budgetary appropriations so as to eliminate these issues as classified special emphasis programs."

I. "A system that is quality oriented in fact, as well as philosophy, easily distinguished by the specialness of its mission, and the quality and commitment of its employees.

It will be a system that is credible, therefore accountable and defensible to all. It will be a system which is vitalized by a rededication of commitment by the country at large -- therefore, no longer subjected to the constant vacillation of "to-be or not-to-be'." That shall not be the question! Veterans, who have already spoken for themselves and their country, will hear a nation-wide advocacy for their needs.

Our purpose in this regard will be recognized when leadership positions such as the Administrator of Veterans Affairs, and the Chief Medical Director are tenured, not time-limited or political appointments. Through the quality, continuity strength and commitment of our leadership we will achieve the greatness of our stated purpose."

4. Thank you for the opportunity to share our thoughts with you. I hope you will find them helpful.

Barbara Small
BARBARA A. SMALL
Medical Center Director

SENATE . . . . No. 1824

The Commonwealth of Massachusetts

INTERIM REPORT

OF THE

SPECIAL COMMISSION ESTABLISHED (UNDER SECTION 291 OF CHAPTER 351 OF THE ACTS OF 1981, AS AMENDED BY CHAPTER 191 OF OF THE ACTS OF 1982) FOR THE PURPOSE OF MAKING AN INVESTIGATION AND STUDY OF THE CONCERNS OF THE VIETNAM WAR VETERANS

Senate, January 24, 1983.

The Commonwealth of Massachusetts

Special Commission on the Concerns of Vietnam Veterans

The Honorable Edward J. King
Governor

The Honorable William M. Bulger	The Honorable Thomas W. McGee
President of the Senate	*Speaker of the House*

INTERIM REPORT

The Honorable Francis D. Doris
Chairman

The Honorable Thomas J. Vallely
Vice-Chairman

MEMBERS

Hon. Joseph B. Walsh
Hon. Angelo M. Scaccia
Charles N. Collatos
Dr. Louis Bartoshesky
Allan N. Breen
Hon. James M. Connolly
David Entin
Dr. David A. Finkel
James Fitzpatrick
Donald L. Jernigan
Dr. John McCahan
Dr. Richard M. Ryan
Stephen Zardis
Michael Sullivan
Walter Cotter

Paul R. Camacho
Executive Director

The Commonwealth of Massachusetts

LETTER OF TRANSMITTAL

TO: *The Honorable Senate and House of Representatives*

We, the undersigned, having voted in the affirmative to accept this report, do hereby transmit this interim report on the results of that investigation and study, as our first 'interim report' of the commission. The commission was established by Section 291 of Chapter 351 of the acts of 1981. We believe that this report is of tremendous significance to the Commonwealth of Massachusetts and its citizens and are proud to submit this to you at this time.

Respectfully submitted,

FRANCIS D. DORIS
Senate Chairman

JOSEPH B. WALSH

WALTER COTTER

ALLAN N. BREEN

DAVID ENTIN

JAMES FITZPATRICK

JOHN MCCAHAN

MICHAEL SULLIVAN

THOMAS J. VALLELY
House Chairman

ANGELO M. SCACCIA

LOUIS BARTOSHESKY

JAMES M. CONNOLLY

DAVID A. FINKEL

DONALD L. JERNIGAN

RICHARD M. RYAN

MEMBERS EX-OFFICIO:
CHARLES N. COLLATOS
STEPHEN ZARDIS

December 1982

On behalf of the Massachusetts Special Commission on the Concerns of the Vietnam Veterans, I wish to express our deepest gratitude to Mr. Paul Camacho, Executive Director, for his untiring efforts in preparing this interim report of the commission.

Sincerely yours,

FRANCIS D. DORIS
State Senator
Chairman, Special Commission
On The Concerns Of The
Vietnam Veterans

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INTRODUCTION

The concept of establishing a Commission on the Concerns of Vietnam Veterans, originated with the work of Bradford Burns, late and past President of the Massachusetts Vietnam Era Veterans Association. During 1981, the concept of the Commission began to widen in scope. It was recognized that there were several concerns to be addressed. On November 11, 1981, Governor King allocated $100,000 from his Discretionary funds to fund the Commission. By the end of February 1982, the membership of the Commission was fully established and the Executive Director was hired. As the Hearings progressed, it became evident that Legislation would be required to extend the time for reporting, and that there would be a need for additional funding.

In short the mandate of this Commission is to investigate and report its findings, together with legislative and administrative recommendations, pertaining to the concerns of the Vietnam Veterans from the Commonwealth of Massachusetts. In addition, the spirit of this mandate implies a strong, even bold advocacy component be undertaken in behalf of the Vietnam Veterans of the Commonwealth when requested, wherever possible. These efforts have included making calls, writing letters, testifying before committees, and the like, for both individual Vietnam Veterans and related organizational entities.

The number of issues, their complexity and interrelationships present this Commission with a formidable task. A great deal of data has been gathered and catalogued — considerably more than presented in this report, with much of it as yet to be assimilated.

In focusing attention on these issues, the Commission has endeavored to strike a proper balance among them. Unfortunately, some disequilibrium has been unavoidable. For this Interim Report, it is perhaps best to capsulate each of these concerns, note the more established relationships among them, and tender resolutions where possible.

EFFORTS TO DATE

A summation of the Commission's work to date includes but has not been limited to the following. The Commission has:

- held eight Public Hearings across the Commonwealth to gather testimony from the Vietnam Veterans;
- developed an initial brochure announcing the Commission's existence, purpose, and goals. This is now being distributed;

- begun a needs assessment study of incarcerated Vietnam Veterans in the Commonwealth. This is being done with and in cooperation with the Department of Corrections;
- completed all the preparatory work required to initiate a statewide Vietnam Veterans Profile Study. The study will reach 158,000 Vietnam/Vietnam Era Veterans residing in the Commonwealth, and is scheduled to begin January 15, 1983.
- obtained prioritization for Vietnam Veterans:
  - a) with the Executive Office for Communities and Development Fuel Assistance Program;
  - b) as an unserved population in the Mental Health portion of of Alcohol, Drug Abuse and Mental Health Services Block Grant.

The Commission has:

- advocated in behalf of the University of Massachusetts/Boston Veterans Upward Bound Program;
- advocated in behalf of the Vietnam Veterans of Barnstable County who desire the establishment of an Outreach Program Center in the Cape Cod area;
- worked closely with the Vietnam Veterans of Massachusetts, Inc. with regard to the passage of H6731 which provides permanent space for the Vietnam Veterans in the Statehouse;
- been cooperating with the Board of Directors of the Federal Action/Vietnam Veterans Leadership Program in an advisory capacity;
- advocated in behalf of the Vietnam Veterans before the Executive Council in connection with the special circumstances of incarcerated Vietnam veterans;
- assisted approximately fifty individual Vietnam Veterans with specific problems;
- assisted the Vietnam Veterans of Massachusetts Inc., with the planning and execution of their organizational retreat of August 1982;
- guided and participated with the Vietnam Veterans of Massachusetts, Inc., in a presentation of Vietnam Veterans concerns to the Massachusetts delegation in Washington. Members of the delegation, including the Speaker, gave us up to two hours of their time;
- lobbied against federal legislation HR5203 — which would have reversed years of EPA regulations, superseded states

rights, and provided for indemnification to corporations;

- participated in a seminar on the concerns of Vietnam Veterans and their dependents for the staff of the Regional Office of Human Development Services, U.S. Department of Health and Human Services, Region I.

PUBLIC HEARINGS

One of the first projects undertaken by the Commission was to hold a set of public hearings so as to roughly ascertain the nature of the concerns of the Vietnam Veterans. Eight general hearings were conducted by this Commission at the following locations this year:

Fall River, Ma.	March 10, 1982
Worcester, Ma.	April 7, 1982
Springfield, Ma.	April 15, 1982
Greenfield, Ma.	May 4, 1982
South End/Roxbury, Ma.	May 11, 1982
Lowell, Ma.	May 20, 1982
Gardner Auditorium, Boston, Ma.	May 27, 1982
Hyannis, Ma.	September 23, 1982

At each of these general hearings, the testimony of those in attendance was directly recorded by a Certified Public Stenographer (or transcribed from tape recording as was the case with the Fall River Hearing).

At each of the eight general hearings, several themes or concerns were repeatedly brought to the attention of the Commission. This list of concerns ranges from issues particular to Vietnam Veterans because of military service and the nature of the war, to those more staple concerns negatively affected because of the nature of the Homecoming experience and the unique negative status of the Vietnam Veteran. Assisting the Vietnam Veteran to overcome these problems by way of its investigations and recommendations is the principal purpose of this Commission.

THE RANGE OF ISSUES

The staple concerns, all of which are affected by combinations of the particular problems mentioned above, include such items as general health care, education, employment, housing, and relations with government agencies such as the Veterans Administration.

The particular issues include such concerns as the problem of a long standing negative and distorted public image, the problem of post-Vietnam delayed stress, difficulties faced by those with less than honorable discharges, the special difficulty of the incarcerated Vietnam Veteran, and the problem of exposure to toxins such as Agent Orange, dapsone and the like, as well as concern for our POW's/MIA's.

Both an examination of the growing volume of literature pertaining to the problems faced by Vietnam Veterans, as well as the testimony provided by the Vietnam Veteran from the Commonwealth, indicate a strong set of linkages between and among the particular and staple issues of concern. In short there is no linchpin problem which if solved will eliminate or resolve the others. Each of these difficulties has to be squarely faced and at least partially surmounted in order for a general improvement in the social condition of the Vietnam Veteran to take place.

Agent Orange

Of all the concerns of the Vietnam Veterans, perhaps the most sensationalized has been that of Agent Orange. The issue is an extremely complex issue involving medical, political, economic, and moral/ethical components. Consequently, the Commission has decided to move carefully in addressing this matter; at this point in time our recommendations are limited to medical matters. We will have a more comprehensive set of recommendations in the final report.

For the purpose at hand, it may be of help to provide an overview of this issue, despite the risk of being over simplistic. During the Vietnam conflict, the United States military (and perhaps others) utilized a series of herbicide chemicals with various code names in a campaign (operation Ranch Hand) to defoliate entire tracts of jungle vegetation in Vietnam for the purpose of denying the enemy cover for their operations.

During this process, crops and waterways were contaminated. Further, both Vietnamese and Americans were evidently affected. That is, Vietnamese living in the targeted area were sprayed. U.S. soldiers came in contact either by handling the material, or by being directly sprayed, or by working in areas which were sprayed, etc.

During the mid 1970s, a number of veterans began to talk of their ailments one of which was a series of symptoms which included recurring rashes. A Veterans Administration worker in

Chicago began to document complaints of the veterans and the story of the use of these chemical agents, of which the most common was called Agent Orange. The issue began to expand and eventually found its way into the news media. It started a stampede of interest in the entire subject of defoliation, chemical/biological warfare, toxic effects, and herbicide use in general.

Many who testified before the Commission specifically inquired about the possibility of connection between Agent Orange and birth defects in their children such as cleft palate, cleft lip, and the like. In addition, they were concerned about Agent Orange and any connection to cancer.

Again, Agent Orange is one of a series of chemicals produced for agricultural use. To be brief it is not the chemical compound (A.O.) itself per se but the contaminants (dioxin) which are unavoidably produced in the production process. Particular "batches" of A.O. may have contained more dioxin than others. One could speak of clean and dirty producers of Agent Orange, as well as of clean and dirty dumpers.

Dioxin is one of the most deadly toxins ever produced; there is no doubt of this. It has been proven to have a variety of deadly detrimental effects on laboratory animals. It is claimed to be misogenetic, carcinogenic, etc.

A series of complex and interconnected questions are involved here.

1) How much exposure (parts per trillion) must be in the human body to cause similar damage?
2) How can the veteran prove that any ill effects he suffers are connected to exposure and that this took place during his military service?
3) How can the symptoms of adverse effects be established?
4) Questions remain as to the problem of determination of responsibility for treatment and compensation.

The Commission has held a special hearing on this matter (November 17, 1982) at which the medical aspect of this question was addressed (transcript available). In the judgment of the physicians who testified, the VA's study (now transferred over to the jurisdiction of the Atlanta Center for Disease Control) was methodologically unsound. The more fascinating highlights of this testimony include that:

- the VA contracted out to a chemist Michael Gross at the University of Nebraska a pilot study of 30 people to take a "fat biopsy" to determine the amount of dioxin in their body. The study was sound in that levels of dioxin were verified. However, the VA never followed through with additional studies, which could have resulted in positive findings.
- The physicians testifying before the Commission were skeptical of other methodologies particularly the study the responsibility of which shifted from the VA to Atlanta's Center for Disease Control. Evidently, they intend to interview veterans by phone and **plan no examination of children.**

Recommendations

At this point the Commission recommends a legislative appropriation of $325,000 dollars for two Agent Orange studies.

Study (1) supports a study the design of which could chemically detect and correlate known exposure to dioxin in Vietnam, the presence of symptoms, and the evidence of disease and tissue (fat) levels in the veteran. Such a study has not been done.

Study (2) a collection of accurate information by examination of a great many children (of veterans and non veterans) from which a comparable data base on birth defects of the children of veterans can be documented. This also has not been done.

The undertaking of these two studies is highly recommended by the Commission. This will at least provide some insight into the size of the problem for Vietnam Veterans in Massachusetts. Other recommendations will be forthcoming.

Post Traumatic Stress

The issue of Post Traumatic Stress or Post Vietnam Syndrome (there exists a variety of synonymous labels) in connection with those who served in Vietnam was first mentioned in the general social/psychological literature in 1973. Perhaps the most significant in this area has been the research sponsored by the Disabled American Veterans Forgotten Warrior Project and the various monographs produced by members of the Consortium on Vietnam Veterans Studies 1980.

These studies, the work of the DAV Outreach Program, and advocacy by numerous others led directly to the establishment of P.T.S. as a recognized mental illness by the American Psychiatric Association early in 1980, and to the Veterans Administration recognition of it as a service connected disability in October 1980. Further it is primarily in response to this issue (and in reaction to pressure from other agencies) that the Veterans Administration established the VA Outreach Program, a counselling program physically based at over 100 "storefront" locations across the nation. It might be pointed out that this project is the only VA program with total support from the Vietnam Veteran community.

One of the most important impacts this research has made is in the criminal justice area. In several cases in states across the nation, including Massachusetts, the relationship between Post Traumatic Stress and crime has been established and accepted in several jurisdictions as a defense or as a rationale for mitigation of sentence. The most recent case in Massachusetts was the Vanderpool case for commutation. This was just recently approved by the Executive Council.

At this point the Commission:

— Recommends that full awareness of this recognized disability be brought to the attention of all state and local agencies where relevant.

— strongly recommends that the legislature with/through the Congressional delegation do all it can to secure three additional Veterans Administration-Operation Outreach Program centers specifically for the Commonwalth, and recommends expansion for the entire program nationally. Further, the Commission strongly recommends that the entire program be given more autonomy to advocate and work for Vietnam Veterans in all the issue areas of concern. Finally, this recommendation includes the note that these centers be open at least a half day on Saturday to accommodate those fully employed.

Drug and Alcohol Abuse

The problem of substance abuse may be closely connected to the P.V.S. factor. Many Vietnam Veterans have unfortunately resorted to drug and/or alcohol as an escape from the bitter alienation and/or anger which frequently accompanies the stress problem. In the literature there is considerable documentation of this problem and it was brought to the attention of the Commission directly or indirectly at all hearings. The most tragic problem, albeit rarely discussed (and hardly mentioned during the hearings) is that of suicide. There are no statistics, but since December 14, 1980, at least a dozen Vietnam Veterans from the Commonwealth have taken their own life. While stress was no doubt the primary factor, the symptom of substance abuse must be seen as a contributing factor.

The Commission:

- has secured prioritization for Vietnam Veterans in the Mental Health portion of Alcohol, Drug Abuse, and Mental Health Services Block Grant;
- intends to develop a seminar program package on Post Traumatic Stress/Drug and Alcohol Abuse which can be tailored for symposiums for various state and local agencies.

Governmental Services

The notion of agency-client relations was a frequent and implied topic of complaint by veterans who testified before the Commission. That is, the testimony documents a plethora of complaints involving the personal experience of the veterans, which taken collectively can only be seen or incorporated under such a theme as governmental services. While the majority of complaints were voiced concerning the VA, difficulties concerning treatment accorded to them by other agencies at the state level was also mentioned. That is in the general area of human services, the veteran was often maneuvered to the Veterans Administration, as if the existence of that agency disqualified those persons from being eligible for services by state agencies.

Frequently, the complaints concerning the VA were tied to statements (or contained in the context of statements) about the good treatment. Now whether this is so in fact is not without question, especially when the topic is restricted to health care. There is probably a set of misperceptions operating here, for certainly both generations of patients are being seen by the same doctors at say Court Street Outpatient Clinic, or any other VA facility for that matter. It is doubtful that the differences of opinion (those that really exist) between the new and old veteran, in connection with the perception of the VA's health care system, are a result of a real disparity in treatment.

No, rather — and perhaps more significant — these conditions, where they do exist, are a real function of structural conditions. That is, the VA essentially responds to its largest constituency or client population, ie., the WWII veterans. During the late 1940s, through the 1950s and 1960s, the needs of the WWII veterans were substantially different from the needs they began to face through 1970s to present. There is no question that the VA is gearing itself toward geriatric health care. Further this is understandable given the shift of needs this population faces. The extent to which this is the case then can be seen as an indication of the lack of attention necessarily paid to the Vietnam Veterans in terms of their health needs. To the extent that any agency budget is finite, there is a zero sum game among its client population.

At this date the Commission notes and/or recommends the following:

1) The Commission intends to hold a hearing this spring which will be entirely devoted to the problems Vietnam Veterans are confronted within terms of governmental policy and governmental relations at the local, state, and federal level.
2) The Commission encourages the Legislature to pass on some formal recommendations to the federal delegation for a significant expansion of the VA Vietnam Veteran Outreach Program in Massachusetts.
3) The Commission strongly recommends that the Governor's Veterans Advisory Board (implemented by the present administration) be maintained by the incoming Governor throughout his term of office and that this board be increased in membership. Further it is suggested that the board more evenly distribute its efforts so as to assist the Vietnam Veterans.
4) The Commission urges all the various agencies to prioritize Vietnam Veterans as a population in need. The Commission further recommends that the executive branch issue a policy statement which prioritized Vietnam Veterans across the board in the Commonwealth.
5) The Commission urges the executive and legislative figures to encourage local communities to maintain autonomy for the veterans service Agent position and appoint a qualified Vietnam Veteran to these positions (presently, less than 15 of approximately 250 veterans service agents are Vietnam Era Veterans). Further the Commission recommends the executive branch to maintain the level and status of the position which the Department of Veterans Services presently holds in Human Services.

Minority Concerns: Blacks/Hispanics/Women

A large number of Black Vietnam veterans leaders met with the Commission Chairman and others to express the need of addressing Black and other minority Vietnam veteran concerns in the Interim Report and not to defer until the Final Report in order to help expedite these recommendations. The Commission agrees and shares the deep concern for all Black Vietnam veterans. It is felt that the following represents the basic and essential points which the minority veterans requested be mentioned and addressed in the Interim Report.

At the outset it should be noted that the overall character of race relations within the United States Military in Southeast Asia followed those racial experiences which unfolded in American society. The time lag (approximately two years) can be explained by reference to the "closed society" or isolated nature universal to any military structure. It is suggested here, that in this framework the racial experience of the American soldier in Vietnam constituted an intensified microcosm of the Homecoming experience. It is felt this parallel holds in terms of both structure and process — from Homefront to Battlefront to Homefront.

While never utopian, race relations between Black and White soldiers had developed to at least tolerable levels in the early 1960's. This held through the early war years; then Vietnam was viewed as an adventure rather than the quagmire it became. Youth, bravado, and the inevitable comradeship which develops under fire worked to counter or at least defuse most of the existing racial tension. Yet as with virtually every issue or factor pertaining to our engagement in Vietnam, race relations within our military deteriorated as the war wore on. By the early 1970's, the hostility became even lethal, and spread throughout our military. There were a multitude of causes for all this, and no listing of specific factors would suffice as explanation. The overall cumulative external military and political situation exerted such crushing pressure on the American soldiers toward the end that it is quite surprising that racial conflict was not worse than it was. Further, it has been remarked that it was a credit to soldiers of Vietnam and the United States Military that they could withdraw under such pressing external circumstances and remain intact as a military force.

The factors immediately impacting upon the Black soldier of Vietnam and the consequent "Homecoming" are briefly outlined for this Interim Report in terms of the induction phenomenon, the military experience, the discharge process, and the "Homecoming" paradox.

In terms of the induction process, project 100,000 is of particular importance here It constituted a policy of the United States government whereby the military test entrance score requirements were relaxed. The ostensible rational operating was that such a policy would move the proportionate armed services Black/minority population up from 8% to 11% and thus reflect the overall composition of our society. Further, it was advanced that such a draft formula would work to allow nominally deprived inner city youth to enter service, acquire positive social skills, earn veterans status, obtain the appropriate benefits, and advance in terms of upward social mobility. Of course, all this should be placed in relief against the landscape of the "Great Society" urban programs with their remedial accent on the minority family structure.

Yet this benevolent test score discrimination failed to operate beyond induction. Consequently, when in service, virtually all were assigned combat military occupational specialties. Few translatable skills were to be found. As military men of color generally faced more obstacles to promotion, those identified as project 100,000 participants were routinely by-passed unless amazingly exceptional. Also the "100,000" soldier was generally barred from re-enlistment; for all practical purposes they were coded to fail.

It is generally agreed that all the disparities and problems of Vietnam became readily apparent after TET 1968. Racial conflict within our military was no exception. The military response was severe. In 1971, the Congressional Black Caucus noted that half of all soldiers in military stockade were Black.

In 1970 the change in draft laws left the college student unprotected; this condition superimposed upon a national loss of purpose, and anxiety over the cumulative casualty toll. The administrative response was the program of Vietnamization and a step-up in the air war; ground troops became "obsolete." As troop withdrawal began, the "rear areas" in Vietnam became extremely tense. Facing an explosive and exploding personal situation the military employed a streamlined administrative discharge procedure, which left many soldiers with "bad papers."

The paradox and tragedy of the Homecoming for the veteran of color consisted in this. The most racially integrated community they ever experienced was filled with violence and dispair. Like all veterans they returned to a negative economic situation, without skills; further, those with "bad papers" were denied benefits altogether. The positive privilege and benefits of veterans status was not forthcoming; more shocking, they returned to the segregated community they left, now in ashes, unorganized — a Vietnam at Home.

Several studies reflect the consequences of this on the minority veteran. Seventy percent of Black Vietnam veterans returned home with one or more adjustment problems such as alcohol/substance abuse, nervous/psychological problems and the like. Eighty-three percent who did so still suffer. According to the same source, the figures are 59% and 58% for Caucasians.

With an unemployment rate in the high twenty percentile and no opportunities, reliance on other than legal opportunities was inevitable as the criminal justice system intervention which followed in turn. The cycle of disenfranchisement from benefits, alienation, and rejection has hit all veterans to be sure. Yet it would be remiss not to acknowledge the intensity and extent to which these negative effects have hit the minority veteran.

Based on input from the minority community, the Commission notes the following problems and makes the following recommendations:

1) It should be noted that problems exist as to the accuracy of information potential clients receive when applying for benefits from local veterans service agents. Also administrative or legislative action should be taken to clarify or repeal the "indebtness provision" — VS20A — agreement to reimburse in the case of retroactive payment from another source. As is, too much arbitrary discretion is left to the local veterans service agent.
2) That high priority recruitment of minorities be established in the various social services agencies of the Commonwealth and that workshops be established for sensitivity training.
3) A funding mechanism be developed for the establishment of a community based residential treatment center for minority

veterans suffering from severe stress disorders and related problems.

4) That the Office of Personnel Administration assemble a statistical profile on minority veterans so as to provide comparative analysis of hiring patterns among state agencies for all segments of the population in both civil service and non-civil service employment. This should include a comparison of minority Vietnam veteran hiring accomplished under affirmative action as against veterans preference.
5) If the life of the Commission is extended, then more minorities be appointed to the Commission and to staff positions.
6) That special programs for minority veterans be implemented within the University, State and Community College system of the Commonwealth. Upward Bound style programs should be established at Roxbury Community College, U-Mass., and Springfield Technical Institute.
7) That access to the system be provided through special outreach efforts. These should include the mandatory prioritizing and recruiting of minority veteran community service agencies as vendors to administer the delivery of various community services, as established in the Federal Block Grant programs. Such Vietnam veteran groups should be directly involved in veterans program design, implementation, and administration under the F.J.T.P.A. in their service delivery area. Further, funding mechanisms Vietnam veteran outreach services should be developed to assist with problems of stress, discharge upgrade, skills development, etc.
8) That an informational brochure be developed which identifies the existing benefits available and clearly outlines the necessary procedures the veteran is to follow. Such brochure(s) should be culturally orientated, i.e., targeted for the particular community at hand — Black, Hispanic, Cape Verdean and Women.
9) That after the termination of the Commission, an agency or department be charged with the responsibility to continue the investigatory work, strongly advocate for follow through implementation on all these recommendations, and perform appropriate monitoring functions.

10) Minority veterans testifying at the Harriet Tubman House were very outspoken with regard to governmental agencies. In their opinion, services to the minority community are characterized by a delivery system both insensitive and unresponsive to their problems and needs. Several examples of racial discrimination in employment within the essential service sector, i.e., city worker, fire, and police, were presented to this Commission. One case of severe racial violence within the Boston Fire Department was cited.

11) **"PTSD":** Women are not included in PTSD studies to date. It must be emphasized that combat is not the only cause of PTSD among military members. State and local agencies who may be faced with a client population that includes PTSD victims should screen women for veteran status. An effort should be made by Vet Centers to have operational hours and daycare referrals that will enable working women, single parents, and women veterans with children to utilize these facilities.

12) **"Government Services":** The Veterans Administration does not maintain sufficient data on women veterans who use its services. V.A. Health Care does not address the needs of the growing female veteran population: Lack of OB/GYN facilities; PTSD wards closed to women; lack of information on access to V.A. paid civilian doctors; lack of sensitivity on part of V.A. personnel in regards to women veterans.

    Veterans' service officers, employment, and educational counselors are generally ignorant of the needs of women veterans and frequently alienate women from the pursuit of their entitled benefits.

13) That the special concerns, needs, and problems women face with regard to other issue areas be addressed in the Final Report.

Housing

The housing problem faced by Vietnam Veterans and their dependents is also an area of principal concern which was repeatedly heard at the Commission public hearings. The literature and statistics here are slim. One could refer to it as an hitherto unrecognized difficulty. Certainly, it is linked to the housing stock problem we all face, and also connected to employment/income problems. What is unique for Vietnam Veterans is illustrated by contrast to what was available to the WWII veteran generation. We refer here to the old chapter 200 program which operated very efficiently during the 1950s. This program fell into disuse as the generation established itself during those years. By the early 1960s, it was rapidly becoming a non-problem. Later the old veterans housing was absorbed into the general public housing programs in this state with the advent of the Great Society programs and the enormous growth of the old HEW bureaucracy.

Now, the returning Vietnam Veteran (especially those most in need) have not had the advantage of a similar program.

The GI Bill loan program has fallen short in the difficult economic times of the late 1970's. Also savings and loans agencies were less than enthusiastic toward the GI loan guarantee during those years.

However, recently there has been a turn around in lending institution policy toward the VA guaranteed loan. The problem may have been the VA.

The Commission was informed in one case by a business realtor that his company has "lost closing" on two houses and two condominiums waiting for VA approval. One Vietnam Veteran had to be granted three deadline extensions. At this time the Commission has no knowledge that this is an example of a general rule. A survey of banking officials and realtors will serve to provide more information.

At this point the Commission is endeavoring to determine the extent of home ownership among Vietnam/Vietnam Era Veterans in the Commonwealth by way of the profile survey we will be conducting in the near future.

In addition, the Commission's research to date has tentatively identified several possible avenues to alleviate the situation:

1) obtain a real percentage quota (say 20%) of all existing and new construction under chapter 705;

2) obtain Vietnam Veterans preference for single family housing board program MFHA;
3) return to low interest fix rate mortgage for veterans (as in the Cal-vet program);
4) continue with securing and maintaining veterans as has been done with the CAP agencies Fuel Assistance Program.

Education

A number of Vietnam Veterans who testified before the Commission pointed out that for them educational advancement was a key problem.

As with virtually all the concerns affecting Vietnam Veterans, the issue of education is not without controversy. Here both the facts and their interpretation are often brought into contention. On one hand exists the argument that the Vietnam Veterans in general have a higher educational level of attainment than that achieved by his WWII/Korean counterpart. Further, the Veterans Administration indicates that more veterans from Vietnam have used their educational benefits than ever before. In contrast to this, a variety of Vietnam Veterans and several behavioral science researchers have contended that these statistics if accurate, are nonetheless misleading. The demographic background of the bulk of Vietnam Veterans cast suggest that the accuracy of these figures is doubtful. They also point out that given the changing social environment the relative need for education between the generations is substantially different, and this fact alone distorts any such educational level comparisons.

Arguing in behalf of the Vietnam Veterans, the Commission notes several other salient points. First, it is without doubt that more, and higher levels of education are required than ever before. It may be said that the era of any individual pursuing one or two career tracks in his working lifetime has passed, given the present employment environment. In the trades, horizontal or transferable multiple skills are increasingly important if one is to survive cutbacks and layoffs. Similarly in the "white collar" world the undergraduate degree is often not enough for entry, much less advancement. What is needed is education/training for jobs for the future.

A second point to consider is one which highlights how these issues have a cumulative "snowball" character which negatively affects the Vietnam Veteran. To wit that thousands of

Vietnam Veterans underwent an intense disenchantment and disorientation upon arriving home and consequently became recluses for years, is common knowledge. The point is that now that enough of this inner turmoil has been settled, they are currently faced with the fact that in the interim they have lost out because of the eligibility delimiting dates. The frustration experienced by these veterans unable to attend post secondary classes cannot be overstated; the ambiguity should be removed. There is need for assistance which is directed to the evening or part time student.

The Commission's recommendations at this point include the following:

1) Recommend the passage of HR 6099, which will enable Vietnam Veterans to attend classes in the evening at state institutions at no personal expense. Further, it will revoke the requirement that the Veterans federal benefit be exhausted.
2) Urge the Legislature to allocate at least $250,000 in the U-Mass./Boston line budget for the funding of the William Joiner Center for the study of war and recovery at the Harbor campus, recently established by Chancelor Corrigan. The center is the first of its kind in the nation and was established to offer courses and conduct research on the Vietnam decade. In addition, it is designed to offer needed academic and supportive services to Vietnam Veterans.
3) Request that the incoming administration immediately establish the State Job Training Coordinating Council which is required for the implementation of the DOL/VES-Jobs Training Partnership's Act signed by President Reagan on October 13, 1982.
4) Encourage the Massachusetts delegation to work to end the delimiting dates for Vietnam Veterans to utilize their federal benefits or at the least extend the date to an additional period of time.

Employment

The employment problem experienced by the Vietnam Veterans since their return has not yet been alleviated. It should be remembered that the older generation of veterans (WWII/Korean) returned to a generally expanding economic milieu despite occasional economic slumps. In contrast, the Vietnam Veterans have faced a negative economic climate. Further, the nature of the economy increasingly requires not only a higher level of competence but also multiple skill capabilities from those seeking employment. In addition, it can be said that in many cases, those who fought in Vietnam never possessed such skills; nor have they really had the opportunity to acquire them, since their return.

Comments pertaining to this situation and numerous complaints concerning apprehension on the part of employees if not outright discrimination against hiring the Vietnam Veteran were voiced at all the public hearings. The existing literature and the investigative work taken up by the Commission to date bears all this out.

By far most of the complaints or inquiries that the Commission has received concern civil service.

The complaints pertaining to federal civil service involve the Post Office. Yet it appears that it is at the state level that the problem is most acute. It is apparent that over the years civil service in the Commonwealth has been circumvented of ways and for numerous reasons.

The circumvention of this preference has had a tremendous negative impact for the Vietnam Veterans. In many cases the veteran was/is not thoroughly aware of his civil service rights, and often was/is not informed of these rights or of the proper procedures to follow when seeking civil service employment. The filing of the notice of interest card (Veterans Application for Provisional Employment — form No. 82 5/78 —) for provisional appointments and the follow-up procedures pertaining to this, is just one case in point. Apparently, there has been a lack of follow-up on the part of appointing authorities as well. They do not bother to inquire whether the veterans' preference card has been filed. Another fact is that in its present form, the state civil service act contains conflicting sections making equitable administration virtually impossible.

Currently, the Commission:

1) Intends to hold a Commission hearing during Winter/Spring 1983 which is specifically concerned with the problem of employment in the civil service sector.
2) Recommends the creation of legislation which penalizes

administrators who purposely circumvent veterans preference in hiring and which gives the Personnel Administrator authority to appoint the qualified veteran if it is determined his rights were violated.

3) Is taking an advisory role in the federal Action/Vietnam Veteran Leadership program presently being established in the Commonwealth.
4) Is committed to insuring a follow through with the federal job training partnership act now coming forth from the DOL/VES.
5) Is developing contacts with the Small Business Administration to aid Vietnam Veterans in securing services and aid from this agency.

POW/MIA

Almost ten years have passed since the Vietnamese delegation signed the Paris Peace Accords (January 27, 1973). The repatriation and/or accountability of the POW/MIA's was one point of these accords. Although the Vietnamese did return some POW's in 1973, there is strong evidence indicating that all have not been returned.

George Brooks of New York, one of the founders of the National League of Families, Prisoners of War and Mission in Action, has interviewed many Vietnamese refugees (the "boat people") who have claimed to have seen Americans in Vietnam. In almost all of these cases the testimony was corroborated by polygraph tests. Four hundred of these sightings are considered to be positive. According to the League, approximately 2,500 POW/MIA's remain in Indochina. Sixty of these are from Massachusetts.

The POW/MIA issue is perhaps the most tender point among the series of issues connected to the agenda of the Vietnam decade. This very sensitivity and the feeling of helplessness at the individual and societal level which accompanies it no doubt accounts for the lack of attention paid to it. Thus if the nation has suffered considerable amnesia in connection with Vietnam and its veterans, with regard to POW/MIAs, it may be said to be virtually comatose.

The lack of accurate information on the existing situation in Southeast Asia, and the myopic nature of relations among the major powers and the various client status (and fractions within client states) surely is problematic for our nation's most able State

Department officials and intelligence officers — and obviously all this is well beyond the means of this Commission.

However, this Commission can engage in a most productive activity, ie., that of promoting issue visibility, which is essential to keeping this issue on the national and international agenda.

Therefore, the Commission makes the following recommendations:

1) That the Commonwealth commit itself to an awareness campaign about the plight of POW/MIA's throughout 1983, the 10th anniversary year of the signing of the Peace Accords. A televised media and selective bill board campaign should be undertaken by the state (with cooperation of the media to abosrb some of the cost in the spirit of public service) which will give a high profile to the issue.
2) The Commission strongly urges that during the week of January 24-29, 1983, all the Massachusetts legislators and the principal administrative figures personally write President Reagan in cooperation with his request for letters of concern and inquiry, which in turn will provide him with ammunition to move on this issue in the international arena.
3) In addition, this Commission recommends that all citizens of the Community write a letter of protest to the Vietnamese embassy demanding a full account of those missing in action.

Negative Public Image

It is a matter of common knowledge that for years Vietnam Veterans have been stigmatized with a brutal and unwarranted negative public image. The root of this problem reached deep into the history of the nature, and outcome of the Vietnamese conflict and the public turmoil which surrounded the entire Vietnam decade. The absence of the legitimacy which an official homecoming experience would have provided is another important factor. It left them vulnerable to attacks from all quarters of the American society. On one hand, the veteran was chided and rebuked as a poor soldier and blamed for "losing the war," on the other for being a "killer of women and children." It is no exaggeration at all to say that Vietnam Veterans became the all-duty scapegoats for virtually every sector of American society, each seeking a way to resolve themselves from responsibility for the war, its outcome and aftermath.

Furthermore, all this has been exacerbated by the media in general. In the film industry, in the newspapers and magazines publications, and especially in television programming, Vietnam Veterans at large have been portrayed as dangerous pathological figures — a menace to society.

This history of neglect coupled with the general societal rejection, and the negative image presented by the various media institutions have had wide ranging ramifications for Vietnam Veterans. For example, such a negative image factor can be directly correlated to discrimination in employment. This has not only been pointed out in the growing volume of literature on the subject, but was also substantiated in the public hearings which the Commission held.

Incarcerated Vietnam Veteran

One of the most tragic phenomena of the aftermath of the war concerns the number of Vietnam Veterans who in one fashion or another have come to be subjects of the criminal justice system. The thrust of the literature indicates that the Vietnam Veteran differs significantly from the general penal population. These differences include a lack of criminal history prior to military service, and a lower than average disciplinary record while incarcerated. Most crimes committed by those Vietnam Veterans incarcerated have been drug or alcohol related, and did involve violence. Further, these various governmental publications, social scientific papers, as well as the claims of advocates approximate that nationally, 20% of the male population at the state and federal institutions for the last ten to twelve years is comprised of Vietnam Veterans. The figures for Massachusetts have not been verified over all these years, but recent studies by the Department of Corrections put the total military veteran population at various MCIs at 15%. This figure does not include those who may be at County facilities.

Over the past several years, various individuals from the Vietnam Veteran community, as well as from the Commonwealth's criminal justice system, have taken interest in this matter. More recently the connection between Post Traumatic Stress among Vietnam Veterans, and incidents of violent street crimes (most crimes by Vietnam Veterans were committed within a year and a half after their return) have come to the attention of researchers, the courts, and other sectors of the criminal justice system.

As a result of the groundwork accomplished by those interested in this matter, and the recent acceptance (though not unanimous) of the connection between P.V.S. and crime, work in this area is at the threshold stage. With the cooperation of DOC with significant input from the Governor a committee has been established to address the problems of the incarcerated Vietnam Veterans in the Commonwealth. The Commission is working in full cooperation with this committee and with the Department of Corrections.

The Commission:

- study on incarcerated Vietnam Veterans is well underway;
- intends to utilize the findings of this study as the basis for the development of a treatment program package to assist the incarcerated Vietnam Veteran's successful return to society;
- has and is continuing to sensitize the criminal justice system to the unique circumstances of the incarcerated Vietnam Veteran;
- has intentions of developing an informational workshop on Post Traumatic Stress geared specifically for the judicial system.

Less Than Honorable Discharge

The punishment and difficulty many veterans of the Vietnam conflict have suffered because of bad paper in the majority of cases far exceeds the nature of their infractions. It should be noted immediately that the situation here was drastically different from this nation's previous conflicts. Data is unavailable at this time, but it is the impression of the Commission that the vast majority of these less than honorable discharges were reviewed by soldiers who fought late in the war, after 1970 — when the entire war effort was beginning to collapse, certainly at home and in Vietnam.

There is some literature which indicates that for many, the less than honorable discharge resulted from an inability to adjust to stateside reassignment for the few remaining months of service **after** their Vietnam service. It is the understanding of the Commission that the early release program employed by the Armed Forces was instituted because of this very problem, and therefore, automatically contained a built-in inequity.

The Commission:

- recommends a total review of the federal government's procedure.

SUMMARY

It is the intention of this Commission to continue to work on all of these areas of concern to the Vietnam Veterans of the Commonwealth. Again, given the number of concerns, their complexity, and interrelationships (among all the issues and especially those relationships that hold between the two general categories — particular and staple) this Commission is faced with a very difficult task. For the purpose of this Interim Report, it is perhaps best in summary to provide a listing of the major goals the Commission plans to attain.

The Commission:

1) will have completed its profile study on 158 Thousand Vietnam Veterans and thereby possess the hard statistical data necessary to resolve the various claims about the status of the Vietnam Veteran in the Commonwealth;
2) intends to hold issue area hearings on the problems Vietnam Veterans have with:
    - The Veterans Administration and other agencies;
    - education;
    - employment;
    - housing.
3) will have developed several pieces of legislation designed to mitigate the problems faced by the Vietnam Veterans in the Commonwealth. Among these issues, those of employment, housing, education/job training;
4) will have developed a comprehensive referral handbook for the Veterans of the Commonwealth;
5) intends to have an Agent Orange study well underway which will provide needed medical information;
6) will have completed its needs assessment with regard to incarcerated Vietnam Veterans in the Commonwealth.

TESTIMONY OF ROBERT L. PHILLIPS

PRESENTED BEFORE THE SUBCOMMITTEE OF HOSPITALS AND HEALTH CARE OF THE VETERANS AFFAIRS COMMITTEE OF THE U.S. HOUSE OF REPRESENTATIVES, AUGUST 9, 1983, IN BOSTON, MASSACHUSETTS

Good morning. Thank you Mr. Chairman and distinguished members of the subcommittee:

My name is Robert L. Phillips, and I am a 36 year old Viet Nam Veteran from North Cambridge, Massachusetts. I am currently receiving care within the Veterans Administration system at the Bedford House, at Edith Norse Memorial Hospital in Bedford, Massachusetts.

Two years ago before I sought help I was working as a district sales manager for a large corporation, and success came to me at a rapid pace. Along with that success came a substance abuse problem which lead to financial disaster as well as the loss of my self respect.

The Veterans Administration, via the Bedford V.A., reached its hand out to me and pulled me into care. After eighteen (18) months of personnel examination, group and individual therapy, dealing with my issues relative to Vietnam, I have now been able to go into the work force once again. I am currently working for a telecommunications firm as a sales manager, and am regaining the trust of my family and friends as well as reimbursing my creditors.

I am able to say that my future looks bright thanks to the help and aid of such programs as the Bedford House within the V. A. system. This program, as well as others, have produced hundreds of more successes.

My fear is that the hand that reached out for me and others is losing the firmness of its grip. I feel that budget cuts have now caused the hospital administration to jockey people around, and that our program is a target for phasing out. Out program at the Bedford V.A., which so many men rely on, has seen four (4) staff people leave because of carreer moves or transfers, and they have not been replaced which means that the remaining staff must pick up their work load.

Presently a social worker who has been with the program for twelve (12) years is about to be transferred, and he will not be replaced. There are only two (2) social workers on our unit, and now the other social worker's duties will increase two fold.

His responsibilities, besides theraputic, are to aid the men in their legal problems, accompany them to Court, and to visit our penal institutions to interview veterans that may want that one chance to turn his life around and become a productive person in society. The repore which he has made with the Courts took a number of years to obatin.

I have brought with me letters of testimony from men who this man has helped, namely: Ed M. and Jessie, C. who has made the Dean's list, Richie, a hairdresser, Bob, who is a welder, Mike a plumber, Preston who works as a presser, Richie G. the student chief and others.

This program and staff men like Roger, is a vital support system for hundreds of men. I wonder now who will go to Court or visit our prisons such as Walpole and Attica. Paul Camacho has stated that our penal institutions are now housing such vetrans who need that chance.

Gentlemen, I realize that budget cuts are necessary, and we all have to live with them, however, I [we] ask only when you juggle the books and jockey people around you consciously examine those programs that are vital to the vietnam era veteran and others who rely on such programs so that they can live, and live a good life.

Out country called on all of us, and we responded at the siege of the Keh San, Da Nang and the Mekong Delta. We only ask you to hear our call, and that call is to keep our program and others in tact.

In closing I would like to read the philosophy of our program.

Mr. Chairman: (see attachment)

"The answer to your question about the future health care within the V.A. system. I hope that the quality of care remains and its programs remain in tact for those who have served its nation with honor."

PHILOSOPHY

The ultimate goal of our family is to create a meaningful life; to heighten self-awareness. We have been blindly leading irresponsible, empty lives; thus, our values have proved to be unrealistic and our behavior inappropriate. To achieve self-awareness and meaning in our lives, we must question and examine all behavior and values continually; for the unexamined life is now worth living.

No one can change our lifestyles but ourselves, and here we have the chance to examine and to change. We can and will help each other, but that help is hopeless without self-help. Thus, support and protection of our family unit is vital. To fail in that support and protection is to put the family in danger. Thus, to be a member of this family is to be devoted to self and every other family member. To be a member of this family is to be committed to honesty, change, and unguarded growth.

We the family, are responsible to ourselves as well as to all members of the family - so that together we will grow.

NO MAN IS AN ISLAND

July 27,1983

Dear Sir,

I am writing this letter in reference to the removal of a Social Worker from the D.D.T.U. (Drug Dependency Treatment Unit) at the Bedford Veterans Hospital. The Social Worker himself is Mr. Roger Huckins. He is very soon to be removed from his position on the unit known as the Bedford House. This is a drug free community for veterans with substance abuse problems. The ironic part is that his position will remain vacant due to budget reasons. My purpose for writing this letter is to air my feelings and to ask for some help in any possibility that this decision might be reviewed or reversed. Other avenues have led to dead ends.

So whats so special about this Social Worker? To the people making this decision, probaly nothing.He is probaly just seen as a chess piece to be juggled around in order to satisfy fiscal matters. This is evident from the fact that there was no insight at all into the effects that his removal would have on people. There was no inquiry into the investments Roger had made into the program in his eleven years of employment. There was no inquiry into the effets that his removal would have on his clients and his professional peers. So what about the clients and treatment team people who interacted with him? To them he was someone very special. Roger went beyond his job description and extended himself entirely to people. He had been a part of this unit since the very beginning, eleven years ago. He carried out individual therapy as well as group therapy as well as anyone here. HE developed a network of communication with the entire prison system, parole board, and court systems throughout New England. In fact he was the only liasion that a resident had between the system and this treatment unit. And now with the wisp of a signature he is swept away from this unit and will not be replaced. And people are expected to take it on the chin and adjust to the changes without wavering one bit.

Well this decision leaves myself and a number of others feeling quite agitated and a little hopeless in what to do or where to turn. So in closing I do not know of much more that can be said. And I really don't know how much good this letter will actually do. But a lot of us did want to be heard. Many of us are Vietnam veterans and have learned through experience that it is usually fruitless to argue with the United States Government. Policies are policies and red tape is red tape,so most of us usually stop when are head gets to sore from banging it on the wall. But now we need some help and are asking you. If your hands are tied we understand but any support that you or your colleague's can render would be deeply appreciated. A nation is only as strong as its veterans. And a veteran is only as strong ar his support system. But at the present time our support system is being slowly dismantled. So we call to you for help.

Sincerly Yours,

Robert E Hollard
Timothy DuPont
Anthony Cousens
Daniel D Wilson
James B. [illegible]
Paul Josephson
Robert Holley
John Watkins
Edmund Monto
Anthony Kalaj
Michael J Hurley
William Tilley
Gerald Kubik
Robert Damsewicz

Richard Gozun

Kevin P Mansef
Jesse J. Cotton
Douglas Burke
Philip N. Duchette
Willie Brown
Michael B Coor
Edward M [illegible]
Richard Osorio
Robert L. Phelps

6:10 P.M. 7-24-83

To whom it may concern

My name is Richard Osorio. I have been involved in the Bedford house program since December 10,th 1980. I came from the street jungle of New York City not knowing whom I was. I was lost in a complete darkend life of drug addiction since the early age of 14 years. I had no sense of direction nor values for myself. However, on my arrival to the Bedford house I became involved in treatment. If it where not for the Staff reaching out with total support in my effords to find myself and seek a new direction in life, I would not be the hairdresser I am today. If it where not for the openness of such Staff members as Roger Huckins I would only be a burden to life itself today. I owe my life and future to persons such as Roger. My fear of this program coming to a halt, which there is talk of, is madness beyond compare. For all that are, or have been within the halls of this building, is the stopping place of rememberinses of the life they and I lived before coming to Bedford. My therapist holds a part of me here which I hope will remain secure for others who follow me. I Sincerly hope to whom letter is in hand, that some very honest thought be considered before any Staff is removed or talk of closing even glitter into someones thoughts

Yours Truly
Richard Osorio

July 24, 1983

Dear Sirs:

I am currently residing in the Bedford House at the Bedford Veteran's Administration Hospital my name is Gerald Kubik.

I am a disable Vietnam Vet and at the age of 34 yrs. old I have finally suffered enough pain physically and mentally to want to stop the use of stimulants. I have been in this program for one year now and hopefully I will need the support and caring attitude of this program to stay straight once I leave these doors.

I am angry about the rude awakening of one our social workers Mr. Roger Huckins being reassigned to another unit.

This loss is personal because Mr. Huckins works with me to understand my feelings and to express them properly instead of acting them out. I hope you can be some help in this matter because Roger is irreplaceable when it comes to dealing with human lifes.

I hope your ears are open to listen and just not to hear me.

Because my ears were open when my country needed me and now I need some help from my country.

It would be appreciated if I can receive a reply on this matter.

Sincerely,

Gerald H. Kubik
200 Springs Road - 70A
Bedford, Ma. 01730.

I AM A VIETNAM ERA DISABLED AMERICAN VETERAN. I SUFFERED FROM PULMONARY TUBERCULOSIS, FAR ADVANCED, SHORTLY AFTER MY RETURN FROM THE ORIENT IN 1972. I ALSO RETURNED HOME AN HEROIN ADDICT. I WAS VERY ALIENATED AND DEPRESSED UPON MY RETURN TO CIVILIAN LIFE. DISPITE MY PROBLEMS I MANAGED TO COMPLETE FOUR YEARS OF COLLEGE AND SECURE A JOB IN THE FIELD OF SIGN ADVERTISING. MY IRRESPONSIBLE LIFESTYLE FINALLY CAUGHT UP WITH ME IN 1981. THREATENED WITH THE LOSS OF MY WIFE OF SEVEN YEARS AND MY TWO BEAUTIFUL CHILDREN, HAVING BEEN UNABLE TO HOLD A JOB FOR TWO YEARS DUE TO ALCOHOLISM, I FOUND MY WAY TO THE BEDFORD HOUSE.

THE BEDFORD HOUSE HAS OFFERED ME NO LESS THAN A SECOND CHANCE. THE BEDFORD HOUSE IS COMPLETELY UNIQUE. AND IS, WITHOUT A DOUBT, ONE OF THE BEST REHABILITATION PROGRAMS IN THE COUNTRY. ALCOHOL DETOXIFICATION PROGRAMS WITH

BEST COPY AVAILABLE

EXTREMELY POOR SUCCESS RATES, AS WELL AS ALCOHOL EDUCATION PROGRAMS (30 DAY WONDERS) ARE EVERY-WHERE. AND COST TAXPAYERS PLENTY.

IRONICLY WITH THE EVER INCREASING DRUG PROBLEM AMONG VETERANS, A SUCCESSFUL, HIGH QUALITY DRUG AND ALCOHOL REHABILITATION PROGRAM SUCH AS THE BEDFORD HOUSE IS THE FOCUS OF BUDGET CUTBACKS.

A SERIOUS, LONG TERM READJUSTMENT PROGRAM WITH THE GOALS OF MODIFYING DEROGATORY AND SOMETIMES ANTISOCIAL BEHAVIORS AND PERSONALITY TRAITS. WHICH AIDS THE RECOVERING VETERAN IN BECOMING A USEFUL AND PRODUCTIVE MEMBER OF SOCIETY AGAIN IS A LOW PRIORITY.

PLEASE CONSIDER WHAT WE ARE TRYING TO DO HERE. WE NEED YOUR HELP.

SINCERELY WITH GRATITUDE,
JAMES CARSON

BEST COPY AVAILABLE

I am a resident here at the Bedford House. This place is for all veterans who are in need of help with overcoming their drug and alcohol problems.

I am 26 years old and have been in the Bedford House for over a year. I am now on 2nd phase in the program and I will soon be leaving the house.

When I first came here, my life was in total shambles. I felt washed up at age 24. I had no job, place to live, friends or just about anything worth while going for me. I was very hopless.

Now two years later, with the help of this program. I've turned my life around. I now hold down a full time job, have a car and am planning to go to school this fall. I have friends both here and on the outside now. Every month I take a trip home to see my parent's. They are my friends now

Rather than go on and on, I will get to the point with my letter. One of our two social workers, Roger Huckins is being removed from our unit and being placed elsewhere in the VA system. Roger has been in this unit for many years and has helped a lot of people besides myself.

He is also my therapist and has helped me through a lot of issues which I've had to work through. His patience and guidence has helped me a whole lot.

If Roger has to leave this unit it will effect me alot. But I think I'm now strong enough to make it. However, what about the people behind me? They won't have the chance to get the help that I've had from Roger.

I really don't have much hope that this letter writing will help. I've never been one to write letters, sign petitions or get involved in anything like this. But right now I don't know what else to do. Can you help us?

Sincerely,
Paul Josephson

July 24, 1983

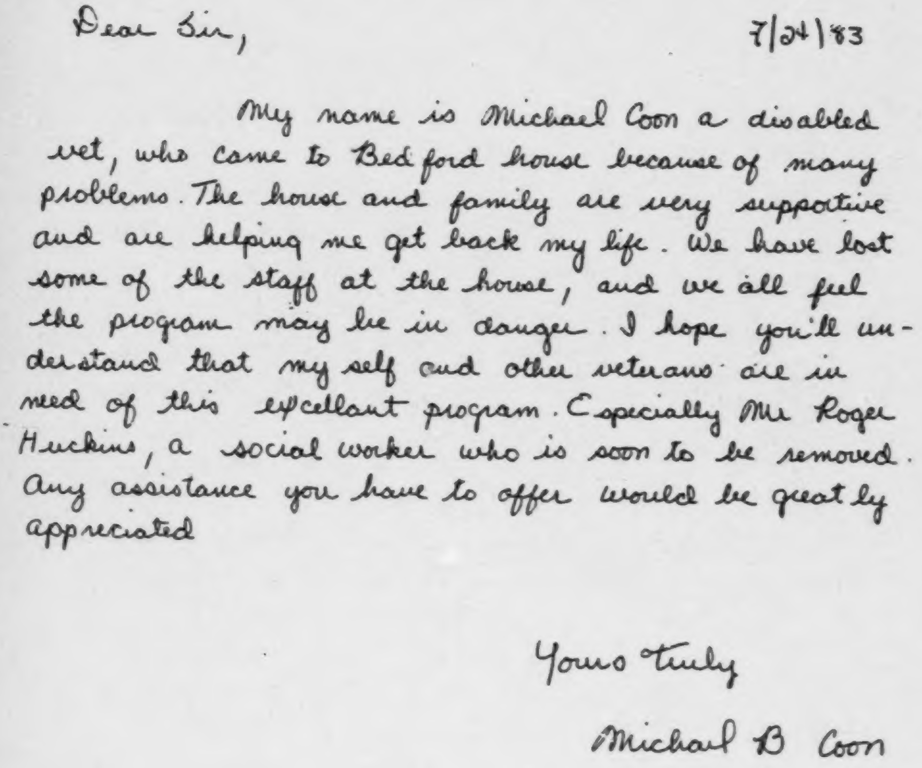
Dear Sir,

I am presently a patint at the Bedford House, the drug dependency unit, at the Bedford Veteran's Administration Hospital, Bedford, Mass. I admitted myself to the hospital three months ago, feeling fearful and hopeless, no longer able to or responsible enough to hold onto a job, full of guilt, because of the grief and and hurt I caused my wife and 8 year old daughter, and serious legal problems, which I got involved with, after losing control in my life. All this is due to my use and eventual abuse of drugs, which I foolishly told myself, its something I could handle, only to find myself with my life wrecked and in the gutter.

Since I've entered the program, I've begun to feel some hope and, although difficult, I can turn myself and my life around in a positive direction, and most important, all isn't lost. This sense of hope didn't come to me alone, but only through the support and caring of the staff members at the Bedford House. Roger Huckins is one of the Staff members, and for 11 years at the Bedford House, has been able to effectively get through to persons, like myself, to take responsibility with our lives and believe that change, although scary, will happen. This is definitly not an easy task, and you must admit, with the drugs problem at epidemic proportions, qualified and dedicated individuals, like Roger, aren't exactly a majority. In fact, from my personal experience, there are very few that would even know how to help a person like myself, except to medicate with a substitute drug avoiding the real problem altogether, or temporarily incarcerate, or just throw their hands up in frustration.

My question is then, why take an effective Social Worker and therapist, as Roger is, out of the drug dependency unit, where he has been successful with a group, that historically the helping profession has been unsuccessful at, and transfer him to another part of the V.A. system? I understand that budget cuts are something we all have to live with and a necessity most of the time because of the times, but is it economically expedient to remove an employe out of a position, he is extremely skilled at and definitly needed, and is an integral part in justifying the annual budget allocated to the program through his successes in helping a problem that affects everyone one way or another? I would appreciate any help, you may have to offer, in helping us to retain Roger at the Bedford House, and still receive the help we need to turn our lives around, from him. Thank you.

Respectfully
Edward M. Fogarty



Dear Sir, 7/24/83

My name is Michael Coon a disabled vet, who came to Bedford house because of many problems. The house and family are very supportive and are helping me get back my life. We have lost some of the staff at the house, and we all feel the program may be in danger. I hope you'll understand that my self and other veterans are in need of this excellant program. Especially Mr Roger Huckins, a social worker who is soon to be removed. Any assistance you have to offer would be greatly appreciated

Yours truly

Michal B Coon

July 24, 1983

Dear Sirs,

My name is Richard A Medici, I am a Viet Nam Veteran, who has a drug problem. I'm 34 years old and have been using drugs for 13 years. I came here to the Bedford House part of the Bedford V.A. Hospital, to straighten out my life. I've been off drugs for 5 months, and with the help of certain people I'm finilly finding my way back into Society.

There's a special person I'm talking about his name is Roger Huckins. I feel his support and help has put me back on the right track, something I though was impossible. I'm finding it hard to believe that due to government spending he's being transfered to another part of the hospital. "What's happening". Are we the Viet Nam vets who fought in a terrible war deserve this. We are tired of it and I'm angry at what's going on. Can anyone help or do something to keep him here. I want to get my life together so please help me, and others who have drug and alcohol problems. We are willing to help ourselves with our problems, with your support and help we will suceed. Please think about it

Richard A Medici

7/24/83

Dear Sir,

My name is Philip N. Dukette. I am 20 years of age, and I spent only 28 months in the U.S. Army I started to drink a great deal of alcohol and also use drugs, This prevented me from finishing my 4 year commitment. I was discharged on June 12, 1982 and very soon after came to the Bedford House. I very much need this program and the staff available. And the removal of Roger Huckins, a social worker here, leaves me with a bitter taste in my mouth. Could you please give me some help concerning the "Why" of this decision.

Sincerely Yours
Philip N. Dukette

July 23, 1983

Dear Sir

I am deeply concerned about the recent decision made that has caused great worries amony myself and many others.

A social worker, Roger Huckins, is being removed from this Drug Treatment Unit of 70A, Bedford, Mass. I am sure when this decision was made, it was not known how vital Roger's job was to this unit and to the people still raven the streets who have not reached this unit through Roger yet.

Roger Huckins has helped many people from New England and surrounding states. If is was not for him, many of us would either be in jail or still running from the police.

I have cried out to other high authorities about this situation and received little response, if any, none that would help. Now I turn to you as my last prayor that this essential person is not taken away from this unit, away from those who need him most.

Sincerely,

Jesse J. Cotton

7/24/83

Dear Sir,

My name is Ed Monti and I am writing this letter about the removal of a Social Worker, Mr. Roger Huckins from the drug unit of the Bedford V.A. Hospital. This removal is due to budget cuts. And Rogers position has been a vital one to this unit for the last eleven years.

I am writing to ask assistance for any inquiry that can be made into this decision. So far all my questions have fell on closed doors.

As a Vietnam veteran I know what it is usually like to question government policies. Red tape and more red tape usually prevail. But in this case I refuse to sit silent.

Roger Hurkins reached out and assisted me when I was down and out. He listened when few others would. And he spoke on my behalf in a court of law. Roger is a vital cornerstone to the functioning of this facility. And now he is to be removed and not replaced. I am bitter and feel very hopeless in this case. Since I've been back from Nam I haven't called very often on my government but now I feel I need assistance. Thank You,

Edmund Monti

To Whom it may Concern:

My name is Robert E. Holland. I am a Vietnam Era Disabled Veteran. I have been in the Bedford House in Bedford Mass. for one year. Which is a Drug Rehabilitation Center. One of our social workers is being taking out of the program with no replacement. His name is Roger Huckins He has helped me personally with Counseling and Court cases I had pending. Also I regained my Drivers license because of him. There has been four staff members taken out of this program without any replacement. I feel that my treatment is being jeopardized.

Before I came to this program I was a Drug Abuser and Criminal. I do not want to return to that Life again. I am worried.

Therefore I pray that you can assist me in getting to the bottom of these decisions. Any assistance would be greatly appreciated.

Thank you
Robert E. Holland.

7-24-83

Dear Sirs:

My name is Douglas J Brooks, I am a Vietnam veteran, honorably discharged on Dec 14, 1970. I have been dependent on drugs and alcohol and unable to be an asset to society. I am now in the Bedford House at the Edith Nourse Rogers Memorial Hospital in Bedford Mass. Since being here I have learned that I no longer must lead an unproductive life. I can learn through this program and the staff that run it what many others before me have. I see much progress in the others who have used this program even after leaving the house and the way they have made their life worthwhile.

It has come to my attention that one of the staff (Roger Huckins) is being cut and not replaced. I have seen the great value he has been here and to lose him can only be felt by the many whom he has helped as the wrong thing to do. He not only helps in legal matters with residents but is also a valued therapist.

I live in Vermont but came here because of the praise of success of this program. To lose even one member of the staff can only contribute to the decline of the Bedford House.

In closing I would only like to say that with the many cuts in these programs that many people (veterans and thier family) will be hurt. I need this program and every staff member here to learn how to make my self an asset to sociaty and not another debit. Thank you for your time.

Sincerely
Douglas W. Brooks

I am a 37 year-old Vietnam veteran who did not feel good about him self. I came to the Bedford V.A. drug treatment house on October 18, 1982. Was having a substance abuse problem with heroin and alcohol. My marriage was slipping away. I have two young boys that need me free from the way I was living before I came to the Bedford House. Upon arriving at the Bedford V.A drug clinic I had numerous encounters with the law and was headed for one of our penal institutation to do hard time. Mr Roger Huskins a social worker from the unit and my therapist, accompanied me to court numerous times with his presence and the reputation of the Bedford House program. I was able to remain in treatment and givin the opportunity to straighten my life out by the courts for which I am thankful. Roger Huckins has and is helping me work through difficult problems in therapy. He is now being transfered to another unit and not replaced. I believe that this is a sign of things to come and that our program is under the sharp pencil of budegt.

cut. Roger Haskins is a vital member of this program and is needed by me and many other veterans who look to him for help. I went to Vietnam when my country asked now I am asking it to help me and a program that I need. I would like your help.

Respectfuley Youre
Robert Danisewicz

DEPARTMENT OF MASSACHUSETTS
AMVETS
AMERICAN VETERANS OF WORLD WAR II, KOREA AND VIETNAM
Chartered By Act of Congress July 23, 1947
ROOM 542, STATE HOUSE BOSTON, MASSACHUSETTS 02133 Telephone: 727-2972

August 3, 1983

Hon. Bob Edgar, Chairman
Subcommittee on;
Hospital and Health Care
House Veterans Affairs Committee

Mr. Chairman:

It is indeed a great pleasure for me to have been invited to address your concerned committee. I am most gratified to have the opportunity to voice the concerns of the AMVETS, Department of Massachusetts.

Until recent years the hospital facilities and health care provided by the VA to the veterans of our country were the very best, second to none. However, since the austerity programs have been in effect, due to cut-backs on allocations, many changes are occurring that concerns the membership of AMVETS in this Commonwealth.

The following are some of the concerns which grieve us to the point we feel compelled to appraise this committee.

1. We are concerned with the use of drugs being used for experiments, such as AZTHREONAM, which is not listed in the PDR, (Physicians Desk Reference), on patients, who in some instances, may be semi-comatose without the opportunity to reject participation in the experimental program. Use of a drug that has not been evaluated in laboratory animals, and approving a protocol to inject and experiment on unsuspecting veteran patients, concerns us very deeply. We ask, "Are VA patients guinea pigs for the pharmaceutical industries and Medical School graduates, or are they being treated as you would want to be cared for ??"

2. We continue to be concerned when we observe the cutting of Nursing positions due to lack of funds, yet spending millions of dollars for unneeded renovations and remodeling just so that the monies allocated this "FY" must be used for that purpose, or next year our appropriations will be cut. May we ask, what is more important for patients care - Nurses or Remodeling?

WE *Fought* TOGETHER . . . NOW, LET'S *Build* TOGETHER

3. The consolidation program concerns us also. Especially when we observe Chief of Departments (on the medical side of the VA operation) are being replaced with personnel that are not "Board Certified". The method used for the basis of selection is the Medical School attended and not qualified ability and expertise. Are we to believe that our VA patients are being used by Medical School Grads to experiment with?

4. Further, we are concerned with the inequity of salaries between Clinical versus Non-clinical personnel, where recruitment of Nursing Assistants becomes very difficult, due to the fact that Building Management and Dietetics employees make more money, such as a janitor and food service personnel (dish washer).

The above are a few categories that we are concerned about, and I am sure that our fellow veterans organizations have some concerns of their own which you have heard, or will hear before this day is over.

We, in AMVETS, have always held the Veterans Administration as the arm of government which has the greatest concerns for our hospitalized veterans. We have, and will, continue to support this outstanding governmental agency. However, the Veterans Administration can only provide hospital facilities and the proper health care that the Congress of the United States allows, or provides.

As State Commander of AMVETS, Department of Massachusetts, may I extend to you, Mr. Chairman, and to the members of your committee, my profound gratitude in appreciation of having the opportunity to address this elite subcommittee of the House Veterans Affairs Committee.

James E Blake

James E. Blake, Commander
AMVETS, Department of
Massachusetts

New England Chapter
Paralyzed Veterans of America
524 MAIN STREET
MEDFIELD, MASSACHUSETTS 02052
Tel. 617-359-2943

STATEMENT OF
WILLIAM C. McLEAN
PRESIDENT
NEW ENGLAND CHAPTER
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF
THE HOUSE COMMITTEE ON VETERANS' AFFAIRS,
THE HONORABLE BOB EDGAR, CHAIRMAN
CONCERNING
INPATIENT AND OUTPATIENT HEALTH CARE
IN THE NORTHEAST REGION
AND
THE IMPACT OF THE AGING VETERAN
ON THE SYSTEM
AUGUST 9, 1983

Mr. Chairman and members of the Sub-Committee, thank you for affording me the opportunity and privilege of presenting to you the views of the New England Chapter PVA on inpatient and outpatient care and the impact of the aging veteran on the system.

The subjects of our concerns and our recommendations are as follows:

1. The first subject we wish to address is the staffing ratio used by the VACO. The staffing ratio in VA hospitals is well below that used in the private sector, especially here in New England and particularly, in the Boston area. The Brockton

and West Roxbury VAMC's administration wishes to bring the level of medical care and treatment at West Roxbury and Brockton to the same level and quality of care that is found in the other teaching hospitals within the Harvard Complex -- hospitals, such as; Beth Israel, Mass. General and the Brighams. This is a highly desirable goal and one we support fully for its obvious effect on all patients at West Roxbury and Brockton; but, it is difficult to imagine it happening with the staffing ratio that we have.

2. The Full Time Employment Equivalent (FTEE) figures used by the VACO do not hold true when compared to the number of persons reporting for work on the wards of the SCI Service.
3. Another area of concern is the tremendous turnover of personnel in the SCI Service which is endemic to the Service.
4. We recommend the following to help correct the above conditions:
   a. A re-evaluation of FTEE figures with the object of bringing staffing to compete with the private sector figures.
   b. A profile be drawn of long serving, dedicated and competent workers in the SCI Service and used when interviewing, hiring, and assigning personnel to the Service.
   c. Further studies to support staffing needs of the SCI Service be done similar to the one now being conducted by Dr. Chi at the Brockton VAMC SCI Unit. It is along the lines of a time study as to how much time is needed to bathe, dress and feed a patient; to change catheters; to

dress decubiti (bed sores); for bowel care; to undress, correct drainage; to administer medications; all these and a myriad of other activities necessary for comprehensive care of an SCI patient. These studies will pinpoint the needs of the SCI veteran and the staff needed to meet these needs.

5. Another subject of vital concern to us is Rehabilitation. Comprehensive Rehabilitation Programs have not improved one iota since WWII and in many areas have regressed. Physical rehabilitation has always played a stellar role in the SCI Service and as good as it is, it is not good enough. Being taught and learning daily living activities, such as; putting on your pants, combing your hair, and using a knife and fork are all well and good and are the basic rehabilitation activities; but, the SCI veteran deserves more than just the basics. New England PVA has learned through the years that one activity that brings all aspects of the rehabilitation processes into play is an active, well designed, disciplined athletic program. The VA games is a case in point. Participation of the veterans in the games shows clearly the interest generated by these activities; and this interest and participation will last as long as the active life of the veteran. Yet, there is no comprehensive athletic program in the West Roxbury SCI Center and very little activity by any of the inpatients at this facility. The Brockton SCI Unit has an active therapeutic recreation program that is geared for the older veteran patient.

6. Vocational rehabilitation for the SCI veteran at the West Roxbury and Brockton facilities is insignificant. There was a CHIRP (Community, Hospital, Industry Rehabilitation Program) program developed at the Brockton VAMC which is now in disarray but that would be ideal for SCI veterans if it could be returned to its former status.
7. We have no qualified Chief of Rehabilitation Medicine Service and at the present time, the hope of finding one is very remote. Until we do, a comprehensive rehabilitation program and any chance of advancing the rehabilitation processes is, in our opinion, hopeless.
8. Our recommendation is as follows: A Chief of RMS who can develop, impliment and maintain new programs and can improve and expand existing programs, be found and appointed regardless of the accommodations that must be made to secure such an individual.
9. Another area of grave concern to us is the establishment of a substance (alcohol and drug) abuse unit. Such a unit is needed for our SCI veterans. Discussions concerning such a unit have been going on for over 4 years with absolutely no progress being made to establish a substance abuse unit. The problem lies in the physical care of the patient. Psychiatric personnel cannot or will not handle SCI patients. SCI personnel are not trained to handle the psychiatric and psycological aspects of substance abuse patients. The Service Chiefs cannot come to a resolution of this problem and all the while the needs of the SCI patients are not being met.
10. Another aspect of the same problem is the patient with psychia-

tric needs other than treatment for alcohol or drug abuse. The same dichotomy exists. The Psychiatric Service and the SCI Service cannot agree on who is to do what, where; and, like the substance abuse patient, the psychiatric SCI patient is not having his needs met.

11. Our recommendation is a 4-6 bed unit in a psychiatric ward at Brockton VAMC with the personnel attending the unit being trained in SCI patient care.
12. Another area of concern is the number of patients who need the diagnostic evaluation that can be made from the results of CAT-scan procedures but who are so immobilized that they cannot be transported across town to the scanners location. Studies done in New York have shown that those patients that most need the scanners procedures are the least likely to receive its benefits for just those same reasons as mentioned above -- their physical condition will not permit them to be moved any great distance. We are also given to understand that any monies spent in contracting for CAT scanner services or used in a fee basis system for the same reason could purchase a CAT scanner in 18 to 24 months depending on frequency of need and distance traveled by patients. For all of the above reasons, we recommend and urgently request that a CAT scanner, meeting the requirements of the hospital, be installed at the West Roxbury VAMC.
13. The aging SCI veteran -- long term or extended care. There are two SCI long term - extended care facilities in the VA system. One in Virginia, the other here in Massachusetts.

The long term - extended care SCI unit at Brockton VAMC is a 58 bed unit with the patient census at 95% occupancy. 80% of the patients are quadriplegics and 75% of the patients are 60 - 65 with a few in their 70's and 80's. Using this unit and its residents as a microcosm, studying the needs of the patients, and programs that have been developed to meet those needs, and conversely the needs of the patients not being met and the programs that must be developed to meet those needs, we can come close to judging what will be needed when the influx of aging veterans, as projected, enters the VA system.

a) Long term - extended care patients. The VA's definition -- those patients who have been in a hospital for a year or longer and who cannot be returned to home or community for whatever the reason. (usually financial and/or family). The vast majority of aging SCI veterans will come under this category.

b) VA involvement in the contracting for and the supervision of nursing homes, extended care units, paraplegic hostelries and domiciliaries must be considered and supported.

c) Dr. Chi's study will help in determining the staffing needs in a nursing home, an extended care unit, or a domiciliary.

14. The Brockton SCI unit was to have had 20-22 beds added while at the same time correcting some space deficiencies, and upgrading fire and seismic safety. This idea was discarded

because of a number of vacant beds at West Roxbury. The next idea was to renovate the Brockton unit to meet the minimal space deficiencies, eliminate 2 beds and much of the patient recreation and therapy space. This idea met a good deal of resistance so another renovation idea was forthcoming. This time space requirements would be met, two beds would be added and recreation space would be maintained by the addition of a glass-enclosed sun room. Needless to say, no decision has been made as yet. We have asked that all construction and/or renovations be held in abeyance until a complete evaluation of patients needs is done.

15. Our recommendation has been, in light of the aging veteran dilemma, that 22 beds be added to the unit while at the same time correcting all deficiencies, while keeping disruption of patient routines to a minimum. We are asking that consideration of the patient be placed before that given concrete, steel, wire, and glass.

16. Our National Office has suggested that a 120 bed extended care unit can be constructed at Brockton VAMC for what one of the renovations would cost. If this is possible, we would most certainly defer to that plan. Whatever action is taken, it must include more beds and it must be started very soon.

Mr. Chairman and members of the sub-committee, this concludes my statement and I will be [illegible] to respond to any questions you may have.

STATEMENT OF

GARDNER S. McWILLIAMS, COMMANDER
DEPARTMENT OF MASSACHUSETTS
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO HEALTH CARE FURNISHED OUR NATION'S VETERANS

BOSTON, MASSACHUSETTS AUGUST 9, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you both for bringing this Subcommittee to Boston for this oversight hearing and, also, affording me the privilege to appear here to present the views of the Department of Massachusetts, Veterans of Foreign Wars of the United States.

My name is Gardner S. McWilliams and it is my singular honor to serve the more than 62,000 men and women of the Department of Massachusetts, VFW, as their Commander. Permit me to point out and make it a matter of record that the VFW is the largest veterans' organization in the Commonwealth of Massachusetts.

Mr. Chairman, the veteran population in the Commonwealth of Massachusetts is presently 720,000, of whom 43.8 percent are World War II veterans; 18.4 percent, Korean veterans; 24 percent, veterans of the Vietnam Era with the additional 13.8 percent consisting of World War I veterans and post-Vietnam Era veterans.

Mr. Chairman, we here in Massachusetts consider ourselves extremely fortunate in that we have five Veterans Administration medical centers located at Bedford, Boston, Brockton, Northampton and West Roxbury. These medical centers operate some 3,139 beds with an average daily census of 84.04 percent.

We also have three nursing home care units at Bedford, Brockton and Northampton totaling 306 beds with a bed occupancy rate of 94.04 percent. An additional 352 nursing care beds are in community facilities under contract to the Veterans Administration.

Mr. Chairman, thanks primarily to the effort of the Honorable Margaret M. Heckler, now Secretary of the Department of Health and Human Services, her tenacious efforts while a member of the United States House of Representatives and a member of the House Veterans' Affairs Committee, we have a jointly operated Geriatric Research and Clinical Care Center at the Boston outpatient clinic and the Bedford Veterans Administration medical center which is proving to be of considerable value to our older veterans.

Mr. Chairman, younger veterans in this state are indeed fortunate in that we have four outreach centers for Vietnam veterans with readjustment problems, two of which are located here in Boston, one in Brockton and one in Springfield, Massachusetts. These outreach centers are well-operated and extremely beneficial. Needless to say, we were delighted to learn that one of the provisions of H.R. 2920, the "Veterans Administration Health Programs Amendments of 1983," passed by the United States House of Representatives, would extend the psychological readjustment counseling centers through September 1987.

It pleases me to be able to state, Mr. Chairman, that I am unaware of any major problems peculiar to VA health care facilities here in Massachusetts. A few years ago we did experience extreme difficulty in the recruiting of licensed practical nurses due to the fact that the entrance level was usually that of nursing assistants. However, VA Central Office issued new classification standards differentiating licensed practical nurses from nursing assistants and the problem was alleviated.

Mr. Chairman, it is my opinion that the health care personnel in our VA facilities are highly competent, dedicated professionals and they do the very best job possible witin the perimeters of budgetary and personnel constraints. Needless to say, it is most distressing that more and more veterans with non-service-connected disabilities are being denied care and referred to community hospitals as welfare patients. Such action robs the veteran of dignity and often results in him or her not seeking care so that the condition deteriorates and often becomes irreversible. We in the VFW hold to the premise that no honorably discharged veteran in need and seeking health care from the VA should be denied that care and the responsibility to furnish such care is that of the federal government.

It is also distressing, Mr. Chairman, that more frequently veterans are being denied over-the-counter drugs and supplies which they need and are often unable to purchase for themselves.

Another area wherein we encounter problems is the delay of weeks and sometimes, months in gaining admittance of a veteran to a nursing home care facility.

We do have minor problems from time to time with respect to appointments for veterans and their treatment which I presume exist throughout the entire VA hospital and medical care system. However, these are normally hardled at the local level by our very capable Department Service Officer, Edward R. DeSimone. Any problems beyond his capability to resolve are referred to our Director, National Veterans Service in Washington, D. C., Fred Juarbe.

In conclusion, Mr. Chairman, permit me to again thank this Subcommittee for taking time from your very busy schedule to travel here to Boston and permit me to appear and offer my testimony.

Statement of
EDWARD W. PARKS
National Director
of
American Ex-Prisoners of War, Inc.
before
Subcommittee of
Committee on Veterans Affairs
August 9, 1983

Mr. Chairman and Members of the Subcommittee:

I appreciate this opportunity to appear before this subcommittee to present the views of the American Ex-Prisoners of War, as well as the former prisoners of war from this area, on the health care delivery by the V.A. and its views on the implementation of Public Law 97-37.

I am Edward W. Parks, National Director of the American Ex-Prisoners of War. I am a World War II veteran and was incarcerated by the German govenment.

Regretfully, I was only notified of this meeting late on Wednesday, August 3, 1983. Three days is not enough time to prepare an adequate presentation to this committee, especially when some have been waiting 38 years to tell their story, but I would like to present a few comments.

The majority of former POWs did not have an adequate repatriation examination (if any) and the later separation physical was also inadequate. To compound the medical records deficiency was the destruction of many medical records in the St. Louis fire. The lack of adequate medical records of this group of veterans is one source of the problem confronting the former POW in his dealing with the V.A. The "Study of Former Prisoners of War," May 1980, also so states that the government was negligent in documenting medical records of repatriated prisoners of war with no follow-up program established.

Most World War II and Korean prisoners of war were young men, 18 to 24 age group, and shortly after repatriation most appeared to have recovered from their incarceration. Problems from disease and malnutrition did not manifest itself until later years.

To quote the POW Study: "Evidence of a significant amount of psychosis among former POWs, many years after repatriation, comes from the National Academy of Sciences, National Research Council follow-up studies, which suggest that "The significantly higher POW deaths from time of separation, attributable to suicide, accident, and other forms of trauma could well be due to extreme psychological stress of the POW experience." Let's all remember that every POW was in a plane that was shot down, a ship that was sunk, or a foxhole that was over-run. He or she, often wounded, then went through the trauma after combat, of capture, interrogation, mistreatment, uncertainty, beatings, and malnutrition. To quote further, from the POW Study, a POW physician: "On return to this country we were amazed that emotional problems were undetected in the fast psychiatric shuffle offered the POWs by physicians only recently graduated."

Based on the "POW Study," Public Law 97-37 was enacted, effective October 1, 1981. The complete implementation of this act will satisfy the needs and problems of most of this group of patriotic Americans. We feel the intent at the highest levels to be sincere and implementing Circulars and Directives issued, but the information, desire and enthusiasm has not always filtered to the lower levels.

The POW Medical Coordinator should be aware of his appointment and his responsibilities. According to PL 97-37 all former prisoners of war should be contacted with regard to the law and the increased benefits availble to them. Most POWs report gastro-intestinal problems connected to the period of malnutrition in which they battled dysentery and other gastro-intestinal diseases. Many POWs are still denied claims even when PL 97-37 recognizes chronic dysentery to have been incurred or aggravated by service. PL 97-37 also expressly states that psychosis or any of anxiety states which manifests to a degree of 10% or more after service, even with no record while in service, shall be recognized. Service connection is still being denied. At this late date, not all of the POW medical files are "flagged" with the POW label, and there is still a callous attitude by some personnel when informed by the veteran that he is a former prisoner of war and should be evaluated under PL 97-37.

There appears to be fewer complaints for dental service to those qualifying under the 6 months or longer incarceration clause under PL 96-22, although we feel this time restriction unfair and so should be re-evaluted. Many veterans incarcerated less than six months suffered dental damage due to severe diet deficiency.

Finally, we see some improvement in the implementation of PL 97-37, but this law has been in effect since October 1, 1981, and some V.A. hospitals and satellite stations are slow to conform to all aspects of the law. The POW and their families have waited too long for a satisfaction to their physical, psychological and economic problems which the implementation of PL 97-37 will address to have V.A. personnel satisfy.

On behalf of this patriotic and patient group of veterans, the former prisoners-of-war, I want to thank the Committee for the opportunity to present comments and I regret that the short three days notice of this hearing prevented me from presenting more specific details of the implementation of Public Law 97-37 in this area.

Thank you.

Congreſs of the United States
House of Representatives
Washington, D.C. 20515

August 9, 1983

Mr. Chairman:

I would like to thank the Members of the Veterans' Affairs Subcommittee on Hospitals and Health ~~Health and Hospitals~~ for holding this field hearing today in Boston. This series of public forums should provide Members of the Committee and the entire House with a better understanding of the health care needs of our nations' veterans.

I would also like to take this opportunity to thank the staffs of the Veterans' Administration Regional Office and the V.A. Medical Facilities in the Greater Boston area. Each and every day, veterans and their families turn to my office for help and the local V.A. offices have always been the most responsive and professional when I have called upon them with these constituent inquiries.

In assessing the health care needs of veterans, I find myself much more concerned with the future than with the present. While I have been alarmed by the major cutbacks sought by the Reagan Administration, my main concern is with the deliverance of health care to the extraordinary number of veterans who will become elderly in the remaining years of this century. It is my sincere hope that the rolls of disabled veterans will not be increased in the years ahead by veterans of future wars. However, the many men and women who unselfishly gave of themselves in past conflicts are now or will soon be reaching the age when medical problems tend to compound. A large part of the burden for these veterans will fall on the shoulders of the V.A. Despite this trend, the Reagan Administration continues to call for drastic cuts in V.A. personnel and overall budget authority. In doing so, the President is asking an agency which will be faced with a major increase in responsibility to meet its mandate with major reductions in resources. We in Congress must make every effort to avoid such short-sighted planning. Instead, we must seek a policy which will ensure that our nation provides for the health care needs of deserving veterans.

Mr. Chairman, I regret that I could not have joined you personally today, but I again wish to thank the Committee for this opportunity to express my views on this very important subject of health care for veterans.

Ed Markey

Outward Bound

Hurricane Island
Outward Bound School
P.O. Box 429
Rockland, Maine 04841
Telephone 207 · 594 · 5548

August 17, 1983

TO: Ms. Barbara Daniel
Subcommittee on Hospitals and Health Care
Room 338
Cannon House Office Building
Washington, DC 20515

FROM: Thomas Stich and Robert B. Rheault
Project Directors
Vietnam Veterans Program
Hurricane Island Outward Bound School
Box 429, Rockland, Maine 04841

SUBJECT: Testimony for the Subcommittee on Hospitals and Health Care for Vietnam Veterans

As the purpose of Chairman Edgar's Subcommittee is to review inpatient and outpatient VA health care in the Northeastern Region, we want to take this opportunity to have entered into the record this testimony regarding Outward Bound's recently instituted program for Vietnam Veterans (particularly those suffering from Post Traumatic Stress Disorder-PTSD).

Outward Bound has a long and successful track record in therapeutic programs for persons with special needs, most notably in this regard, four years of experience in a capacity of adjunctive therapy for veterans at the White River Junction, Vermont Veterans Administration Hospital. More recently Outward Bound has launched a program specifically aimed at Vietnam Veterans suffering from PTSD.

After consultation with the staff of the Veterans Administration Hospital in Northampton, Massachusetts, most particularly Dr. William Boutelle, Chief of Psychiatry and Richard Sette, LICSW, Director of the PTSD unit, Hurricane Island Outward Bound School planned and carried out a pilot model 6 day course in May 1983. The seven participants on this course were all inpatients of the PTSD unit. Outward Bound staff consisted of two senior instructors and program managers, both of whom will be involved in the development of this program and are themselves Vietnam Vets.

The course consisted of many standard Outward Bound activities - camping, hiking, peak ascents, ropes course and rock climbing. It was notable and special in the amount of time and effort devoted to talking, listening, counseling and drawing metaphors from the experience:

- -taking responsibility for ones own life
- -sticking with difficult tasks through completion
- -rediscovering pride in accomplishment and the camaraderie of shared challenging experiences
- -communications vs complaints

Results of the course were rated very highly by participants and observers alike. The director of the PTSD unit joined the course for the last two nights and a day and a half. Extensive debriefs were carried out with the patients and therapists who work with them, and the participants were visited by Outward Bound staff a month later. In June 1983, a presentation was made by Hurricane Island Outward Bound School staff to the participants at a Regional Conference on PTSD co-sponsored by the Veterans Administration and Smith College School of Social Work. The concept, as presented, received enthusiastic response and support from a distinguished audience of psychiatrists, psychologists, therapists and counselors; and we are encouraged to continue.

Our past experience in programs of this nature makes us confident that this type of adjunctive therapy can have a dramatic result in returning patients to full and productive lives; and our plans call for a research project that will support this belief. Obviously, if we can shorten hospitalization stays we can ultimately save a great deal of money.

The problem we face at this stage of a new program is that obviously the veterans themselves cannot pay for the program, and The Veterans Administration is not prepared to allocate any funds yet.

In order to maintain the momentum of what we have started, we have thus far been partially supported by Outward Bound scholarship funds and are now attempting to raise funds from the private sector.

We need help to obtain the support of VA funds to continue and expand this program.

Respectfully submitted,

Thomas Stich
Robert B. Rheault
Project Directors

October 6, 1983

Honorable Robert W. Edgar
Chairman, Subcommittee on Hospitals
  and Health Care
Veterans' Affairs Committee
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Edgar:

At the hearings of your subcommittee in Boston on August 9, 1983, you invited comments about what we should be doing in the Veterans Health Care System in the year 2000. You specifically requested a bit of "blue sky." My comments represent my own views.

There will be major changes in medical practice by the year 2000. I will not try to define specifically in which areas this will be most dramatic. There are several principles which should govern the directions the Veterans Administration should take as it approaches the year 2000.

1. No patient should be treated in a hospital bed who does not need to be there.

The Veterans Administration should decrease its emphasis on beds and begin to emphasize Ambulatory Care, Day Care and Home Care.

2. The Veterans Administration Health Care System should integrate more closely with the private health care system.

Efforts should be made to rationalize delivery of health care within the community. There should be a reduction of duplication of facilities and equipment. Major capital expenditures should be avoided if favorable relationship can be negotiated with the community. Similarly, the VA should be allowed to provide expensive services if these are necessary to work out a favorable quid pro quo with the private sector.

3. Incentives should be created to have elderly, eligible veterans cared for in their homes rather than in nursing homes.

A pilot program should be explored which gives per diem cash payments to families to care for veterans in need of nursing home care in the home. This program would require careful monitoring and quality control.

4. Veterans accepted for care should be guaranteed continuity of care and access to all care (diagnostic and therapeutic) which is generally acknowledged by the medical profession to be efficacious.

Current eligibility rules promote discontinuity and fragmentation of care. It is particularly important in the chronically ill and elderly to have these principles implemented.

Sincerely,

Howard H. Green

HOWARD H. GREEN, M.D.
Chief of Staff
VA Medical and Regional Office Center
White River Junction, VT 05001

Home Address:
9 Brockway Road
Hanover, NH 03755